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CENTER FOR HEALTH POLICY RESEARCH

**RESULTS OF A MULTI-SITE STUDY OF  
MANDATORY MEDICAID MANAGED CARE  
ENROLLMENT SYSTEMS:  
IMPLICATIONS FOR POLICY AND PRACTICE**

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MANDATORY MEDICAID MANAGED CARE  
ENROLLMENT SYSTEMS:  
IMPLICATIONS FOR POLICY AND PRACTICE**

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**VOLUME I  
Main Report  
Appendix A**

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Many people contributed to the completion of this study.

are the numerous state

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# Results of a Multi-Site Study of Mandatory Medicaid Managed Care Enrollment Systems: Implications for Policy and Practice

## Executive Summary

The number of Medicaid beneficiaries enrolled in mandatory managed care programs has grown at a fourfold pace during the 1990s. Enrollment constitutes one of the most important, yet least explored aspects of mandatory Medicaid managed care (MMMC). This multi-phase study<sup>1</sup> of enrollment practices in states using mandatory Medicaid managed care arrangements was designed to address this gap in knowledge. Major findings from this study are:

- 9 *States shared common enrollment process characteristics but varied in their commitment and approach to outreach and education about enrolling in managed care. Intensive use of community-based organizations (CBOs) emerged as an increasingly **successful strategy** for meaningful outreach and education.*
- 9 *Lack of information about providers **and plan** networks consistently precluded Medicaid beneficiary choice during enrollment. This **fundamental** inability to choose has the potential to undermine the FQHCs' strategies to retain patients and gain new patients.*
- 9 *Managed care plans were primarily concerned about unstable markets due to unstable eligibility/enrollment patterns for **beneficiaries** and declining Medicaid caseloads.*
- 9 *For FQHCs, enrollment concerns were important but secondary to reimbursement problems in terms of the compelling challenges associated with surviving managed care.*
- 9 *Medicaid **beneficiaries** reported that the **ability** to choose their providers was most important and that access to information necessary for choice was limited. Their most valued and **effective** sources for such information were their providers and CBOs.*
- 9 *Enrollment plays two critical, and potentially **conflicting**, roles in MMMC: ensuring that beneficiaries get coverage by entering a plan, and creating a market by making blocs of lives available to plans. Autoenrollment was of uncertain and variable importance.*
- 9 *Market pressures on state **officials** to ensure rapid implementation of MMMC **programs** resulted in enrollment procedures and practices that did not give beneficiaries the information necessary to choose their providers and to navigate managed care.*

## Background and Research Design

The first phase of this study examined the role of autoenrollment, the process whereby Medicaid beneficiaries are assigned to managed care plans when they do not voluntarily enroll

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<sup>1</sup> Funding for this study was provided by the Center for Health Care Strategies, a Robert Wood Johnson Foundation-funded project, The David and Lucile Packard Foundation, the Kaiser Family Foundation, and the Health Resources and Services Administration's Bureau of Primary Health Care (HRSA/BPHC).

and choose a **plan**.<sup>2</sup> We found that knowledge about autoenrollment is very limited and that states' autoenrollment policies and practices are highly variable. We concluded that autoenrollment would likely play an important role in enrollment policies and had the potential to affect disproportionately Medicaid beneficiaries and safety net providers.

The second phase, whose findings are the subject of this report, involved a more detailed examination of states' enrollment policies and practices under MMMC and of the experiences of Medicaid beneficiaries enrolling in managed care. The case study approach also involved an assessment of the effects of MMMC enrollment policies on federally qualified health centers (FQHCs) and their ability to survive a changing healthcare system. This aspect of the study was of particular interest to and supported by the **HRSA/BPHC**.

Nine states were selected: California, Connecticut, Florida, Maryland, Michigan, Missouri, New Mexico, Oklahoma, and Oregon. Structured interviews were conducted **onsite** with key informants in each state including state Medicaid officials, managed care plan officials, FQHC representatives, Medicaid beneficiaries, and community advocates. Two focus groups with Medicaid beneficiaries were conducted in each state. Additional focus groups with minority and HIV-infected beneficiaries were conducted in several states in order to gain more detailed perspective on the experiences of potentially harder-to-serve populations.

The research goals were: 1) to gain a better understanding of states' evolving enrollment policies and practices for their mandatory Medicaid managed care programs, 2) to assess the role played by enrollment in developing Medicaid managed care markets, and 3) to examine the experiences of Medicaid **beneficiaries** and of FQHCs as they are required to participate in MMMC programs. Thus, our research questions were:

- How are state enrollment policies and practices developing and evolving as mandatory Medicaid managed care (MMMC) programs are developing and evolving?
- What are the specific state autoenrollment policies and practices under MMMC programs? What role is played by these policies and practices?
- What factors related to the enrollment process affect the decisions and/or willingness of plans, either commercial or provider-sponsored, to participate in MMMC programs? Are states tailoring enrollment policies to solicit the participation of plans?
- How are Medicaid beneficiaries affected by state enrollment policies and practices, especially as these policies and practices affect their ability to choose providers as well as health plans? What are these beneficiaries' experiences with enrollment?
- How are federally qualified health centers (FQHCs) affected by state enrollment policies and practices? Have the FQHCs experienced a loss of Medicaid patients and/or revenues due to particular enrollment and/or autoenrollment policies and practices?

## **Enrollment Policies and Practices – What We Found and What We Learned**

### ***States Shared Common Enrollment Process Characteristics But Varied in Their Commitment and Approach to Outreach and Education about Enrolling in Managed Care***

While states generally used the same basic elements for enrolling Medicaid beneficiaries in managed care, states varied substantially with regard to the commitment of resources for enrollment outreach and education including 1) the role and responsibilities of the enrollment

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<sup>2</sup> Maloy, K.A., Rosenbaum, S., et al. (1997). *The Role of Autoenrollment in Mandatory Medicaid Managed Care*; Washington, DC: Center for Health Policy Research, George Washington University, October.,

broker, 2) the extent to which community-based organizations (CBOs) were meaningfully involved in outreach and enrollment, and 3) how much time states were willing to invest in educating beneficiaries prior to the conversion to MMMC. (See Tables 4, 5, and 6)

State officials also faced a range of pressures to proceed expeditiously in implementing their managed care programs including 1) the participating plans' immediate need for a certain number of covered lives, 2) state budget pressures to move ahead, and 3) legislative expectations of immediate cost-savings in Medicaid. States differed in the amount of time they allowed for initial conversion to MMMC. There was evidence that more rapid implementation of MMMC was associated with more chaotic transitions to MMMC and less knowledgeable enrollees, although not necessarily with higher rates of autoenrollment.

On the other hand, a few states are taking steps to improve their enrollment process by 1) using CBOs to enhance enrollment, 2) expecting more from their enrollment brokers, 3) allowing individual healthcare providers to assist their patients, and 4) using a more gradual approach to establishing MMMC programs. *The use of CBOs is becoming more common as states recognize the value of these entities for reaching harder-to-serve groups. We found evidence that these efforts can improve beneficiaries' knowledge about enrollment and their ability to choose a plan.*

### ***Lack of Information about Providers and Plan Networks Precluded Beneficiary Choice***

Perhaps the most compelling findings concerned beneficiaries' ability to choose their primary care provider (PCP) during enrollment. We found that enrollees were uniformly more concerned about choosing their PCP than their plan and yet, in most states, information regarding providers and plan networks was either highly inaccurate or unavailable to the enrollees. (See Table 8) *Consequently, the beneficiary's ability to choose a provider during enrollment is either 1) foreclosed because this choice is not available or 2) seriously compromised by a lack of information about plans' provider networks.*

The findings also suggest that the difficulties associated with implementing mandatory systems usually made the provision of timely and accurate provider information difficult. Especially during start-up, serious deficiencies in state data and management information systems contributed substantially to the lack of provider information. There was agreement about necessity for a sophisticated and well-run management information systems (MIS) to support the transition to managed care and alleviate information deficits. In the absence of MIS improvements, states have made efforts to correct the effects of poor provider information by allowing liberal plan/provider switching although these policies may not be effective "cures."

To the extent that provider information is not made available, beneficiaries' initial choices of plans and providers (e.g., whether to "go mainstream" or stay with their traditional provider) will be constrained by the enrollment process. For safety net providers, the effects of these constraints frequently meant "lost" patients or patients wanting but unable to return.

### ***Autoenrollment Played a Variable and Uncertain Role in Enrollment***

We found substantial variation among the states with respect to how autoenrollment policies and practices are designed and implemented. (See Table 10) There were no overarching associations between state MMMC characteristics and autoenrollment practices (e.g., lower autoenrollment rates did not routinely occur in states with greater managed care experience) and little consistent evidence that state officials saw autoenrollment as a valuable tool for establishing MMMC programs although the most common use of autoenrollment was to support the participation of public entities by assigning them greater numbers of autoenrolled lives.

While the autoenrollment rate might be considered a useful metric, it does not fully resolve the tension between the desire to establish a well-structured enrollment process and the need to enroll beneficiaries quickly (e.g., more intensive outreach with a longer enrollment period would mean a lower autoenrollment rate), and the data presented *do not represent an informative tool for comparing states and that the multiple measures of autoenrollment precludes drawing*

### **Managed Care Plans- Concerned**

Plans were uniformly troubled about two enrollment issues: the unstable eligibility and enrollment patterns of their Medicaid members, and the impact of the loss of Medicaid members on their expected covered lives due to falling Medicaid caseloads.

Increased competition for Medicaid lives have heightened plans' interest in streamlining enrollment procedures. While plans were generally motivated to respond to

*patients is jeopardizing the survival of FQHCs. These findings highlight that FQHCs must address both the enrollment- and the reimbursement-related policies associated with MMMC.*

The absence of provider information and the lack of informed voluntary choice during enrollment represent the enrollment policies with the most profound implications for the FQHCs. These providers will not be successful in their strategies to retain existing patients and attract new patients if enrolling Medicaid beneficiaries are not able to choose their PCPs or don't have timely access to the information necessary for choice.

Consequently, we concluded that FQHCs must 1) participate aggressively in the enrollment process, 2) ensure that their patients know how to choose them and to access FQHC services, 3) work with the state and plans to ensure that provider networks include all FQHCs, and 4) cultivate improved strategies both to retain current patients and to attract new patients.

### **Medicaid Beneficiaries - Ability to Choose Their Providers Was Most Important While Access to Necessary Information Was Limited But Most Valued From Familiar Sources**

While the use of focus groups limits the generalizability of our findings, the focus group findings provide a rich picture of beneficiaries' enrollment-related experiences. Beneficiaries frequently stressed their confusion and frustration over the lack of information about providers and plans and their inability to figure out how to stay with their provider. Beneficiaries often evidenced a basic lack of understanding about how to use managed care, despite their voluntary enrollment status, and were aware that they needed more information about managed care to access care successfully. *Most significantly, despite the emphasis on choosing a plan during enrollment, most beneficiaries were only concerned about being able to choose their providers.*

We found evidence of initiatives that did improve beneficiary understanding of managed care; *beneficiaries frequently reported that receiving information from their regular provider or from a CBO representative was preferable and most effective.* The experiences of HIV-infected beneficiaries demonstrated the value of face-to-face education and of direct assistance with navigating managed care. Interestingly, Asian and Hispanic beneficiaries did not systematically report more difficulties in dealing with managed care; in fact, these groups were more likely to report access to provider- and/or community-based help with the change. While beneficiaries who had maintained relationships with existing providers frequently reported the fewest problems, most beneficiaries did not have a good understanding about how to use the grievance procedure or how to access specialty care.

### **Implications**

The findings from this study underscore the major enrollment-related challenges inherent in the conversion to mandatory Medicaid managed care: 1) the need to ensure that enrollees understand managed care well enough to preserve and/or create provider/patient relationships in order to access care, and 2) the need to move large numbers of beneficiaries into managed care swiftly and in sufficiently high volume to establish a market.

### ***The Significance of Enrollment's Dual Role***

The enrollment process plays two pivotal roles: 1) ensuring that covered individuals actually enter a plan, and 2) giving states the necessary leverage to create a market among managed care plans through the availability of large blocs of covered lives. These two roles are potentially in conflict because many of the desirable characteristics of an enrollment process

designed to achieve high rate of voluntary enrollment, (e.g., lengthy choice windows or intensive face-to-face choice counseling) could impede rapid establishment of a stable market through the guaranteed enrollment of covered lives for participating plans.

The market pressures on state agencies were evident in findings that state officials pursued a strategy of rapid, large-scale implementation with inadequate provisions for enrollment education and sometimes before contracts with plans were even finalized and provider networks in place. These strategies were driven by concerns about both the plans' immediate need for a certain number of covered lives and the state officials' predictions of immediate cost savings from managed care. More rapid implementation and shorter conversion periods designed to ensure plans an initial number of covered lives very quickly may become the defining consideration for enrollment as states' ability to establish Medicaid managed care successfully will increasingly become dependent upon the willingness of plans to participate.

*The pervasive absence of accurate information prior to and during enrollment about provider networks, and the implications of that absence for beneficiaries and FQHCs/providers, constitute the most important findings in this study and are a direct consequence of the pressures for, and constraints created by, rapid implementation.*

## **Recommendations**

### ***Strategies for Improving the Enrollment Process***

Our findings strongly suggest that high rates of voluntary enrollment are no assurance that beneficiaries can navigate managed care – ongoing and accessible education about managed care that involves all stakeholders, especially CBOs and enrollment brokers is necessary. We recommend specific strategies to improve enrollment and the ability to navigate managed care:

- ❖ Enhance efforts for advance preparation during mandatory enrollment periods with comprehensive information and education available to all stakeholders. Impose more responsibilities on, as well as providing more resources to, brokers to make the enrollment process more accessible to beneficiaries and providers. . .
- ❖ Ensure that comprehensive information about provider networks is available before enrollment begins including how to access traditional providers and specialty care. Increase the amount and quality of community-based education about enrollment that focuses on how MMMC enrollment might affect access to traditional sources of care.
- ⓪ Allow a greater role for providers in educating patients about managed care that includes reasonable safeguards against provider abuse balanced with patient needs. Continue to increase the role of, resources allocated to, and oversight of, CBOs providing ongoing education and support for beneficiaries to navigate managed care with a particular emphasis on their ability to work with harder-to-serve populations.
- ⓪ Solving the problems of poor information is critical. Acquire the technology for sophisticated MIS to generate real-time accurate data about providers, plan networks, and plan membership.

***Broader Strategies Based on Common Interests of Stakeholders***

Public and private policymakers should seek ways to  
spirited problem solving. Common interests are present among the states, t  
plans, beneficiaries, and the



State officials can decide to establish longer periods  
for all beneficiaries (e.g., at least 12 months). This w  
membership, enhance attractiveness of the Medicaid m  
that beneficiaries will learn how to use managed care.



State officials can improve its outreach efforts designe  
eligibles and to reduce the welfare reform-related dyn  
the cracks.” The effects of f  
providing for reenrollment in same plan after short pe

## **Overview of Major Findings**

### *Introduction*

Mandatory Medicaid managed care programs have grown at a fourfold pace since 1990, with current enrollment of almost 50 percent of all beneficiaries. This study, the most detailed analysis of Medicaid managed care enrollment undertaken to date, was designed to examine state enrollment policies and practices under mandatory Medicaid managed care arrangements and to assess the technical, policy, and operational issues that arise in the development and implementation of mandatory enrollment systems. The study also assessed the enrollment-related experiences of Medicaid beneficiaries, health plans, and safety net providers.

The impetus for this study, which was conducted during the winter and spring of 1998, was the desire to gain a greater understanding of the possible causes of high rates of autoenrollment (i.e., mandatory assignment to a health plan following an individual's failure to enroll by choice) in state Medicaid managed care programs. The overall study goal, however, was a broad desire to improve the level of understanding regarding a range of emerging issues in Medicaid managed care enrollment, which is one of the least well understood aspects of managed care, as well as to identify the implications for access and quality.

Before presenting the detailed discussion of all of the major findings, this overview sets forth the most significant findings concerning enrollment and summarizes their implications for the development and operation of mandatory Medicaid managed care programs. We first briefly review the study context and our expectations about the role of enrollment policies and practices in the administration of mandatory programs.

### ***Autoenrollment: The Initial Context***

Autoenrollment, the process whereby beneficiaries who do not voluntarily enroll are enrolled in a plan they didn't choose, is a phenomenon unique to mandatory Medicaid managed care. While autoenrollment of non-selectors is a necessity in coverage arrangements where access to care depends upon plan membership, its use in Medicaid raises certain issues.

Autoenrollment under Medicaid is frequently quite high (e.g., in some states as high as 60 percent to 75 percent). Possible causes of these high rates include the relatively low familiarity with managed care by both states and beneficiaries, the pressures on states to effect rapid transformation of fee-for-service Medicaid, and the limited investment by states in what may be somewhat arduous efforts to promote choice and **voluntary** enrollment. Consequently, Medicaid beneficiaries may be particularly susceptible to disruption of existing provider relationships and an inability to access care in the new system.

Prior to undertaking this study, we conducted a preliminary examination of autoenrollment and the role of autoenrollment in mandatory Medicaid managed care.' We assessed the existing knowledge about autoenrollment in managed care and considered its potential effects on beneficiaries. We also reviewed autoenrollment policies and practices in 34 states with mandatory Medicaid managed care programs. We found that states' autoenrollment policies and practices were highly variable and that there was little evidence of an association between particular state autoenrollment policies and high levels of autoenrollment. We also found that state **officials** and managed care plan representatives were concerned about high autoenrollment rates and the potential for these rates to lead to both negative views of state

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<sup>1</sup> Maloy, K.A., Rosenbaum, S., Teitlebaum, J., DeGraw, D. and Sonosky, C. (1997). *The Role of Autoenrollment in Mandatory Medicaid Managed Care*; Washington, DC: The Center for Health Policy Research, The George Washington University, October.

Medicaid programs as well as uninformed and dissatisfied plan members.

We concluded that the significance of autoenrollment must be examined and understood within the context of enrollment policies and practices, and that a multi-faceted study of enrollment was necessary and warranted. Indeed, while no obvious associations could be discerned between state autoenrollment practices and resulting autoenrollment rates, we felt that the overall structure and actual operation of state's enrollment policies and procedures likely represent the most important factors affecting the incidence and dynamics of autoenrollment. Finally, enrollment policies and practices can provide an informative "window" on a state's approach to mandatory managed care and its expectations for the various roles played by stakeholders (i.e., state, plans, providers, and beneficiaries).

### ***Significance and Challenges of Enrollment***

Enrollment, including the effects of various enrollment approaches on access and quality, constitutes one of the most important, yet least explored aspects of mandatory Medicaid managed care. In a system in which coverage for some or all services is conditioned upon plan membership, enrollment is crucial process. Moreover, because managed care merges coverage with the delivery of health care, the manner in which universal enrollment of the target population is effectuated can carry important implications for access to and continuity of care, the stability of existing provider/patient relationships, and overall patient satisfaction with the managed care experience. Furthermore, enrollment arrangements may help determine the structure of the managed care market. In an industry that requires high volume and steady funds flow to operate properly, a state's approach to mandatory enrollment can influence market entry by various types of managed care plans as well as their stability and survival.

The relationship between managed care enrollment and access and quality may be especially strong in the case of Medicaid. Neither beneficiaries nor state agencies are able to afford the more loosely structured types of managed care products (e.g., point of service plans) that tend to be used by more affluent consumers and that offer greater choice in receipt of care in exchange for an additional fee. Consequently, enrollment in a Medicaid managed care arrangement leads to membership in a system that maintains strict limits on access to **non-emergency** covered care. Because the implications of managed care plan membership are particularly strong for Medicaid beneficiaries, the manner in which state Medicaid agencies achieve mandatory enrollment among the target population holds major implications for beneficiaries and the health care providers that serve them.

In addition, the process of enrolling and informing Medicaid beneficiaries is particularly challenging for states. Medicaid beneficiaries have relatively little familiarity with managed care and are very diverse in terms in terms of education, language, and culture. Many beneficiaries reside disproportionately in medically **underserved** inner city and rural communities. At the same time, state agencies have limited knowledge and experiences with managed care delivery systems and operate under constrained budgets. These conditions are not conducive to a **well-constructed** enrollment process.

There is an evident need to develop a better understanding of how various state enrollment policies are constructed, how the enrollment practices actually work, and the significance of these policies and practices for beneficiaries, plans and providers.

### ***Study Findings Suggest Two Fundamental But Conflicting Roles for Enrollment***

As we examined the findings about enrollment policies and practices across the nine

states and ten sites, it became evident that the overall enrollment process plays two pivotal roles: 1) ensuring that covered individuals actually enter a plan, a crucial step in a system in which coverage and payment for services is conditioned on membership in a plan, and 2) giving states the necessary leverage to create a market among managed care plans through the availability of large blocs of covered lives.

It was also evident that these two roles are potentially in conflict. This is because many of the desirable characteristics of an enrollment process designed to achieve high rate of voluntary enrollment, (e.g., lengthy choice windows, extensive information about plans and provider networks, and intensive, face-to-face choice counseling) could impede rapid establishment of a stable market through the guaranteed enrollment of large bloc of covered lives, with few administrative burdens on participating plans to deal with new members' plan and provider preferences.

#### *Enrollment as Gateway to Managed Care*

States generally used the same basic elements for the enrolling Medicaid beneficiaries in managed care, such as choice windows, employing a broker to inform and enroll, and using enrollment packets. However, we found that states' enrollment policies and practices varied substantially with regard to the commitment of resources for outreach and education around the enrollment process and the level of effort expended to achieve high rates of voluntary enrollment.

Voluntary enrollment rates ranged from 25 percent to 100 percent. Although higher rates were frequently associated with greater commitment to achieving voluntary enrollment, there were no definitive patterns. All states struggled with problems resulting from chaotic initial periods of implementing new systems too rapidly and inadequate state data and management

information systems. On the other hand, our findings suggest that several states are taking steps to improve their enrollment process by using community-based organizations to enhance face-to-face enrollment, by expecting more from their enrollment brokers, and by using a more gradual approach to establishing the new program where implementation occurs by region within a state. We found evidence that these efforts can improve beneficiary knowledge and choice.

In general, however, we found that the procedures for introducing Medicaid beneficiaries to the new system of care were frequently compromised by a conversion process characterized by too rapid change, inadequate support systems, poorly prepared participants, and an unwillingness by states to slow the process and make substantial corrections.

#### *The Role of Enrollment in Creating a Market*

The market pressures on state agencies to maintain their bargaining leverage in creating a market by purchasing care in large, stable blocs were also evident from the findings. State officials, concerned about both the plans' need for a certain number of covered lives within a certain period of time and their own promises of cost savings through managed care, pursued a strategy of rapid, large-scale implementation — sometimes before contracts with plans were even finalized and provider networks in place — with inadequate provisions for enrollment education. High rates of autoenrollment represented an acceptable price, and frequently a valuable bargaining tool, for such responses to market pressures.

In one state, the pressure to create a competitive supplier market resulted in such a complex and multi-layered managed care system that conveying accurate and understandable information to enrolling beneficiaries may have been effectively impossible. Other state efforts to stimulate the rapid creation of a managed care market instead created enrollment processes so bereft of information about provider networks, particularly specialists, that the inevitable results

were the excessive and detrimental autoenrollment of culturally isolated and seriously disabled individuals into plans with inappropriate (and in some cases, non-existent) provider networks.

These market pressures can only be expected to worsen. The withdrawal of managed care plan from Medicaid managed care is front page news in many states, and the enrollee population appears to be dropping precipitously in part as a result of what researchers believe to be the profound changes in Medicaid enrollment resulting from the 1996 welfare reform legislation. At all of our study sites, we found managed care plans uniformly troubled by declining Medicaid rolls, fewer than expected plan members, and substantial monetary losses. As a result, the states' willingness to use enrollment techniques that slowly build a base of informed decisionmaking may decline if such techniques are seen as incompatible with achieving plan participation and market control.

#### *Evidence of Fundamental and Inevitable Tension*

Indeed, our findings point to a fundamental tension at work in the enrollment phase of Medicaid managed care. On one hand, state officials were uniformly aware of the potential for mandatory enrollment to affect access and quality. As a group, officials took the enrollment phase of their Medicaid managed care programs seriously. At the same time, we found a number of questionable practices in states working with limited budgets and under a great deal of pressure to enroll rapidly. The reality of the tension between the need to create and sustain a managed care market and the need to create a well-structured enrollment process was evident.

From a market perspective, the pressures to enroll beneficiaries on a rapid and high volume basis are overwhelming, particularly for purchasers such as Medicaid agencies that pay relatively low rates to enroll relatively sick persons for relatively comprehensive care. Moreover, whether for financial or political reasons or both, the policy goal is to end a fee-for-service

system and to condition coverage on plan membership as quickly as possible: there is an imperative to enroll rapidly. This theme was echoed in many of our interviews with state officials. Speed may dictate less provision of information on the front end and a greater emphasis on “cleaning up” errors and glitches on the back end (i.e., after plan enrollment has been effectuated).

We conclude that the universal challenge for all states establishing mandatory Medicaid managed care programs is the struggle to balance the competing demands of these two enrollment functions. States may not realistically be able to avoid market imperatives no matter how well intentioned about achieving high rates of voluntary enrollment. Moreover, the well-recognized challenges of administering mandatory enrollment systems for Medicaid beneficiaries are exacerbated by the consequences of these enrollment tensions; these dynamics will further mitigate against well-structured voluntary enrollment systems.

### ***The Critical Lack of Essential Information About Provider Networks During Enrollment***

In the case of Medicaid managed care, benefits and cost sharing among most participating plans are very similar because of the structured approach states take to procurement. Consequently, the only true distinction among plans may be in their provider networks. To the extent that this information is not available to beneficiaries, the most important consequences of enrolling in managed care — effects on access to their providers and/or regular sources of care — are lost to the population being enrolled. The findings from this study suggest that the difficulties associated with implementing mandatory systems made the provision of timely and accurate provider information difficult and usually impossible.

Perhaps the most compelling findings concerned beneficiaries’ ability to choose their

primary care provider (PCP) during enrollment. We found that enrollees were uniformly more concerned about choosing their PCP than their plan and that the most common reason for plan switching was the inability to **find** one's provider in the plan. Yet, in most states, information regarding plan networks was either highly inaccurate or unavailable to the enrollees. State **officials** almost universally acknowledged the problems caused by the lack of provider information. Thus, while maintaining prior provider relationships and/or being able to select a preferred PCP has substantial implications for both beneficiaries and **safety** net providers, enrolling beneficiaries generally were not given the opportunity to choose or were unable to make this choice because of a lack of information.

We did find that most states attempted to overcome the effects of the inability to choose — whether due to lack of provider information or autoenrollment or both — through other means. The most notable was the use of liberal, post-enrollment switch plan/provider policies. Two states also required plans to give new members a chance to choose their **PCP**.<sup>2</sup> A few states tried to match enrollees with their prior providers although these efforts were generally undermined by systemic data problems. However, our findings also suggest that liberal **switch** policies create serious problems by affecting the very stability of plan membership and the managed care market that states sought to achieve through a rapid conversion process. Liberal switch policies also lead to delays in payments to plans and providers further exacerbating problems for already overburdened safety net providers.

This lack of information so critical to choice raises a compelling enrollment **issue**: what constitutes voluntary enrollment under mandatory managed care? The implications of our

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<sup>2</sup> While most contracts between states and managed care plans require the plans to give enrolling beneficiaries the opportunity to choose their PCP only if practicable, in these two states giving new enrollees the opportunity to choose was an absolute requirement unqualified by practicalities.

findings indicate that, if informed choice is integral to voluntary enrollment, then there may be little that is actually “voluntary” about these voluntary enrollment procedures. In each of our study sites, the information most crucial to voluntary and informed enrollment in mandatory Medicaid managed care — an accurate, timely, and understandable explanation of which providers belong to what plan networks — either was not available during the enrollment process or was available in an incomplete, inaccurate and potentially misleading format.

Indeed, one of our most notable findings concerns a state that requires Medicaid eligibles to choose a plan as a condition of processing their eligibility and enrollment but does not provide information about plans’ provider networks. While this approach to enrollment meant that the state could report achieving a voluntary enrollment rate of almost 100 percent (i.e., everyone chose a plan), voluntarily-enrolling beneficiaries were obviously required to exercise their choice without sufficient and necessary information.

### ***Reconsideration of Significance of Autoenrollment***

The findings in our prior study suggested that autoenrollment was a **complex** and not easily-categorized phenomenon. The implications of our current findings about enrollment confirm the multi-dimensional nature of autoenrollment and the difficulties inherent in drawing definitive and overarching conclusions about its significance.

A state’s autoenrollment rate could be viewed as a measure of how well the process of voluntary enrollment is working and how knowledgeable enrollees are about managed care. Indeed, a very low autoenrollment rate arguably indicates a great success such as might be claimed by the state reporting the almost 100 percent voluntary choice rate — effectively an autoenrollment rate of zero percent. However, as the foregoing discussion about voluntary

enrollment and informed choice demonstrates, in the absence of a full understanding of the enrollment dynamics, the autoenrollment rate may not be an informative indicator. Simply forcing the elimination of autoenrollment will probably not achieve the presumed goal of voluntarily enrolling informed and knowledgeable beneficiaries.

The inherent tension between creating a well-structured enrollment process and gaining market leverage suggests that the autoenrollment rate might be a useful mechanism for assessing how this tension was resolved (i.e., a low autoenrollment rate indicates that a well-structured enrollment process tends to take precedence over achieving market control). However, our current findings also **confirmed** earlier findings that autoenrollment rates are not an informative tool for comparing states. As in the earlier report, we found substantial variation among the states with respect to how autoenrollment rates are calculated and no overarching associations between state characteristics and autoenrollment (e.g., lower autoenrollment rates did not routinely occur in states with greater managed care experience).

In a few states, higher autoenrollment rates could be seen as the inevitable result of minimal information, confusing and cumbersome enrollment procedures, and an absence of timely and effective counseling or beneficiary support. In other states, the reasons for the level of autoenrollment rates were more complicated. The implications of our findings about informed choice suggest that, in order to measure how states have balanced the tension between informed choice and market power, one must “look behind” the autoenrollment rates and examine the particular context, taking into account states’ efforts to correct the effects of autoenrollment.

Finally, depending on the context and objectives, autoenrollment can be viewed as an acceptable, or at least defensible, policy tool. We found autoenrollment policies contributing to a range of market development approaches including strategies to 1) develop and/or support

publicly-sponsored managed care plans, 2) reward well-performing plans, and 3) achieve conversion from a PCCM to an HMO structure without disrupting existing provider/patient relationships. A major remaining question is whether autoenrollment policies can be used to foster these laudable goals without seriously eroding beneficiaries' ability to choose and access care. The remedy at first blush might appear to be liberal post-enrollment switch policies but these policies undermine the very market advantage that states hope to gain through the deliberate use of autoenrollment policies.

### ***Implications Specific to Plans, Providers, and Beneficiaries***

As the tensions mount between the goals of informed voluntary enrollment on the one hand and the need for rapid enrollment and stable markets on the other, it becomes even more important to understand the ways in which enrollment practices affect the participation of the remaining major stakeholders: managed care plans, providers, and beneficiaries. Although our findings varied across the 10 study sites, broad implications based on the enrollment-related experiences of each stakeholder are evident.

Plans were uniformly troubled about two enrollment issues: 1) challenges presented by the unstable enrollment patterns of their Medicaid members, and 2) fewer than expected covered lives caused by falling Medicaid rolls. Escalating monetary losses and increased competition for Medicaid lives have heightened plans' enrollment concerns, particularly regarding the consequences for stable plan membership of states' liberal plan switch policies to compensate for poor enrollment procedures. Plans were generally eager to respond to autoenrollment-related incentives (i.e., award of autoenrolled lives related to competitive bid scores) but autoenrollment-related concerns were not paramount; the major issue was enrollment overall.

**As** the Medicaid market continues to shrink in terms of covered lives, and as plans grapple with unanticipated challenges, states will likely face increased pressure to modify certain aspects of their enrollment procedures to encourage plan participation. For example, liberal post-enrollment plan switching and the disproportionate award of autoenrolled lives to public plans run counter to the plans' desire for the stability and predictability of the commercial market.

Health care providers are deeply affected by states' approaches to enrollment. We focused on safety net providers, specifically federal qualified health centers (FQHCs), for two reasons: 1) these providers disproportionately serve the Medicaid beneficiaries affected by mandatory managed care, and 2) the level of concern about the survival of these providers because they also disproportionately serve low income and uninsured communities. Numerous enrollment-related concerns were commonly identified across the sites: the adverse effect of enrollment practices on existing provider-patient relationships and the subsequent loss of patients; the general absence of information about plan networks prior to and during the enrollment process; the very poor quality of provider **information** even when such information was available; and the potential for biased provider assignment by plans following enrollment. The absence of provider information and the lack of informed voluntary choice during enrollment clearly have profound implications for the FQHCs. These providers will not be successful in their strategies to retain existing patients and attract new patients if enrolling Medicaid beneficiaries are not able to choose their **PCPs**.

The initial loss of Medicaid patients, as well as payment delays related to plan switching and unstable plan enrollments, have adversely affected these providers' Medicaid revenues. Whether patients were lost as a result of voluntary selection, the effects of poor enrollment procedures, or the recent decline in Medicaid rolls cannot be ascertained from this study.

Evidence in some states that patients were beginning to return to these providers suggests that shifts in voluntary patient care-seeking behavior may be less of a factor in patient losses under mandatory managed care than the effects of poorly-structured enrollment procedures. This finding thus points again to the critical importance of improving enrollment procedures.

While the use of focus groups limits the generalizability of our findings, the focus group study results provide a rich picture of beneficiaries' enrollment-related experiences and suggest many common themes that confirm findings and implications discussed above. Most beneficiaries stressed their confusion and frustration over the lack of information about providers and plans and their inability to figure out how to stay with their provider. Beneficiary responses frequently indicated a basic lack of understanding about access implications of managed care enrollment despite their voluntary enrollment status. On the other hand, beneficiaries were generally aware that they needed to have more information about managed care — indeed, they identified information needs very similar to those voiced by commercial managed care enrollees. However, while we found evidence that it is possible to improve beneficiary understanding of managed care and how to make the system work for them, confirming the findings of other studies of beneficiary education initiatives, it is likely that systematic improvements in the enrollment process will depend more on the current status of market pressures and less on the desire to inform and educate beneficiaries.

***Significance of Accurate Provider Information for Enrollment Cannot Be Overstated and Implications for Improving Enrollment Process Are Profound***

The absence of accurate information prior to and during enrollment about provider networks, and the implications of that absence, constitutes the single most important finding in

this study. The lack of a successful means for dealing with the issue of provider/patient relationships has been the catalyst for many of the other enrollment-related issues identified during the course of the study. In addition, the effects of informed selection of a health plan and provider on the ultimate clinical quality of care has never been measured. However, it is reasonable to conclude that individuals' understanding of managed care, their satisfaction with the managed care experience, and their ability to use services in a manner consistent with managed care design, may be influenced greatly by their level of understanding about the consequences of enrolling in managed care.

Serious deficiencies in state data and management information systems contributed substantially to the lack of provider information. Sophisticated MIS tools are available that would solve many, if not most, of these problems, although the costs for most states would be substantial. Without resource and infrastructure excuses, states agencies would have to deal more directly with how to facilitate informed voluntary enrollment under Medicaid managed care programs. Unless states are able to commit resources to purchasing major technological advances in their management information systems, however, the problems associated with enrollment may not lend themselves to simple solutions in the near-term. This is because the time and effort needed to ensure informed enrollment may work at cross-purposes with the time and market pressures present in the creation of mandatory Medicaid managed care systems.

Moreover, since most privately-insured individuals are now subject to the restrictions on provider choice (even if they can afford to upgrade by purchasing point-of-service products), longer choice windows and more intensive efforts to ensure informed choice for Medicaid beneficiaries are probably unlikely solutions. Perhaps a simpler remedy, which does not address the need for education about managed care but would address the consequences of uninformed

choice for provider access, might be to insist on all providers in all plans (i.e., an any willing provider provision) although this requirement is seen as fundamentally at odds with the basic premise of managed care. Alternatively, another option, designed to address the arguably more serious implications of enrollment for persons with special needs, could be to exempt certain beneficiaries (e.g., the disabled or special needs populations) **from** the routine enrollment procedures and use intensive, targeted enrollment techniques.

### ***Road Map to the Rest of the Report***

This overview has presented the major elements from study findings that shed considerable light on 1) the manner in which enrollment functions in mandatory managed care systems, 2) the policy and practical implications underlying these functions, and 3) the potential consequences of enrollment policies for health plans, safety net providers, and beneficiaries. The rest of this report presents detailed findings in several areas along with a more developed discussion of the implications in each area and related recommendations for how to improve the enrollment process within the context of market-driven imperatives.

## **Discussion of Study Findings and Implications**

In this section of this report, we present the major findings and implications from our site studies along with a series of accompanying tables that summarize the data gleaned from the site visits. By way of introduction, we first briefly discuss the current knowledge and research concerning enrollment policies and practices under mandatory Medicaid managed care, describe the study methods, and present a short description of the study states to provide the context for the findings and implications.

### ***Introduction***

As the number of Medicaid beneficiaries enrolled in mandatory managed care programs has grown at a fourfold pace during the 1990s, reaching a current enrollment of almost 50 percent of beneficiaries, so has the need to gain a deeper understanding of the dynamics of all phases of managed care. The use of managed care affects the delivery of services by changing how providers are paid, developing select provider networks based on price as well as quality, establishing gatekeeper protocols for appropriate care, and offering enrollees financial incentives to receive care from specific providers.

The opportunity and ability to choose as well as the process of choosing a health plan is coming to be understood as important concepts in managed care. Informed and voluntary selection of health plans by consumers is a linchpin of the theoretical framework that underlies the restructuring of the current American health care services delivery system. Ideally, the process of selecting a managed care plan also provides the individual beneficiaries with the opportunity to understand the various mechanics for gaining access to covered health care

services under managed care. The enrollment process is the mechanism whereby consumers exercise their choice and gain this knowledge.

Voluntary enrollment in a particular plan after considering several options is probably a good indicator of an individual's understanding of how managed care, as opposed to fee-for-service, "works". Consequently, high rates of autoenrollment (i.e., assigning non-selecting individuals to plans) are generally viewed with concern because these rates will likely be associated with lack of awareness about plan procedures for accessing services properly and with subsequent improper service use and consumer dissatisfaction - this could also mean a less cooperative and more costly managed care membership.

### *Review of Knowledge and Literature on Enrollment*

As part of our preliminary examination of autoenrollment and mandatory Medicaid managed care, we reviewed the literature and ongoing research on a range of issues related to enrollment including autoenrollment, characteristics associated with consumer choice and satisfaction in managed care, and what influences choice during enrollment. Since the results of this review are detailed and available elsewhere, we provide here **only** a brief **summary**.<sup>3</sup>

In general, the available knowledge about enrollment, autoenrollment, and choice is limited. Because autoenrollment-related concerns are not really factors in commercial managed care enrollment, and mandatory Medicaid managed care is a relatively recent development, there are few informative studies addressing these enrollment dynamics. The findings generally suggest that there is little understanding about the differences between voluntarily-enrolled and autoenrolled plan members in terms of why choice is exercised or not, that there is the potential

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<sup>3</sup> See generally: Maloy, K.A., Rosenbaum, S., et al. (1997) An appendix to this report contains annotated bibliography on the literature. This report is available on the web at <http://www.gwumc.edu>.

for autoenrollees to lack an understanding of the managed care system, and that autoenrolled individuals may delay service use. The only study of Medicaid beneficiaries, conducted in the late 1980s, found that autoenrolled beneficiaries were less likely to have a regular source of health care service, were generally in better health, had longer but fewer hospitalizations, and had lower satisfaction rates.<sup>4</sup>

The knowledge about what information should be made available to individuals to facilitate an informed choice is limited because 1) the traditional research designed to examine how people make choices among health plans has rarely investigated the interaction between the characteristics of the plans and the individuals in terms of identifying exactly why people make certain choices, and 2) the more recent research investigating what consumers want to know is largely composed of reports by consumers about their information needs as opposed to documentation of what information was actually used in the choice process. Thus, before recommendations can be made about how best to inform Medicaid beneficiaries about their choices under managed care, the information that will actually be used by Medicaid beneficiaries and by other beneficiaries enrolled in managed care must be determined.

Other studies examining enrollment issues and Medicaid beneficiaries during the late 1980s and early to mid 1990s suggest that the efforts to educate and enroll beneficiaries are in the early stages of development and being done on a relatively small scale, that outreach efforts can have an impact on beneficiary participation in managed care, and that in-person counseling may be most effective.<sup>5</sup> It is worthwhile noting that, where these articles reported on the

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<sup>4</sup> Hurley R.E., and Freund D.A. (1998) "Determinants of Provider Selection or Assignment in a Mandatory Case Management Program and Their Implications for Utilization" Inquiry, 25:402-410, Fall.

<sup>5</sup> U.S. General Accounting Office, (1996) *Medicaid: States' Efforts to Educate and Enroll Beneficiaries in Managed Care*. GAO/HEHS-96-184. Washington, DC:GAO, September. U.S. General Accounting Office, (1993). *Medicaid: States Turn to Managed Care to Improve Access and Control Costs*. GAOMRD-93-46. Washington, DC:GAO, March.

apparent information needs of Medicaid beneficiaries, these needs were not significantly dissimilar from the information needs of non-Medicaid consumers with the predictable exception that Medicaid beneficiaries were not concerned about price. It is also important to note the results of a series of focus groups with Medicaid beneficiaries in the South Bronx and Harlem whose purpose was to determine what Medicaid beneficiaries understand and what they don't understand about managed care.<sup>6</sup> The researchers found that Medicaid beneficiaries do not understand the basic concepts of managed care and are therefore less able to adopt behaviors that allow them to benefit from the system.

We also examined the results of three current research projects involving efforts to document, track and analyze the evolution of state activities in Medicaid managed care. These projects were being conducted by the National Academy for State Health Policy,<sup>7</sup> health policy consultant Mary Kenesson/dba Health Policy Crossroads,<sup>\*</sup> and the Kaiser/Commonwealth Low-Income Coverage and Access Project.<sup>9</sup>

The main conclusions of the investigators on the Kaiser/Commonwealth Project were not unexpected in terms of pointing out that the implementation of major changes in state programs

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<sup>6</sup> C. Molnar, D. Soffel and W. Brandes. (1996) "Knowledge Gap: What Medicaid Beneficiaries Understand and What They Don't about Managed Care." Community Services Society of New York, December.

<sup>7</sup> *Medicaid Managed Care: A Guide for States*, 3<sup>rd</sup> Edition; National Academy for State Health Policy, 1997.

<sup>8</sup> Kenesson, M. (1997) *Medicaid Managed Care Enrollment Study*; Center for Health Care Strategies, Princeton, NJ., November.

<sup>9</sup> M. Gold, K. Chu, and B. Lyons, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Oregon* (Report of The Henry J. Kaiser Family Foundation and The Commonwealth Fund, Washington, DC, July 1995); M. Gold, H. Frazer, and C. Schoen, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Tennessee* (Report of The Henry J. Kaiser Family Foundation and The Commonwealth Fund, Washington, DC, July 1995); M. Sparer and K. Chu, *Managed Care and Low-Income Populations: A Case Study of managed Care in New York* (August 1997); M. Sparer, M. Elwood, and C. Schoen, *Managed Care and Low-Income Populations: A Case Study of Managed Care in Minnesota* (Report of The Henry J. Kaiser Family Foundation and The Commonwealth Fund, November 1995); and M. Sparer, M. Gold, and L. Simon, *Managed Care and Low-Income Populations: A Case Study of Managed Care in California* (Report of The Henry J. Kaiser Family Foundation and The Commonwealth Fund, May 1996); *Managed Care and Low-Income Populations: A Side by Side Analysis of State Initiatives*, June 1997, Prepared by Mathematica Policy Research for the Kaiser/Commonwealth Low-Income Coverage and Access Project. Gold, et al. 1996. *Medicaid Managed Care: Lessons from Five States. Health Affairs* 15:3, Fall.

is always overwhelming and difficult for states to deal with in a systematic fashion. It is also noteworthy that the first-listed lesson learned concerned the need to invest in an effective enrollment process that includes well-designed written materials, a way to deal with large volume of phone calls, and methods for providing individualized counseling and education for enrollees.

Overall, these projects found that state Medicaid agencies are rapidly adopting the managed care approach to delivering services to Medicaid beneficiaries and are concomitantly restructuring their Medicaid programs. Significant changes associated with this restructuring include more involvement by commercial managed care plans, an uncertain future for traditional safety net providers, more mandatory enrollment for vulnerable beneficiaries such as Supplemental Security Income (SSI) recipients, and more responsibilities shifted to private enrollment brokers.

Enrollment and autoenrollment practices are an integral aspect of the complex factors affecting how and under what circumstances Medicaid beneficiaries are/get enrolled, stay enrolled, determine whether they are satisfied with a plan, and decide what they can/will do if they are dissatisfied. A sign of the how important enrollment has become to beneficiaries, managed care plans, and providers is the fact that the Balanced Budget Act established for the first time minimum criteria for enrollment and autoenrollment in Medicaid managed care programs. The new legislation requires the use of “easily understood” materials “that contain certain information including “the identity, locations, qualifications, and availability of health care services providers,” information on covered services, and information on grievances and appeals.

Our review confirms the uncertain level of knowledge and the need for further research about many important issues integral to the enrollment process including what factors influence/affect beneficiaries' choice of plan and/or provider; how long and intensive should the enrollment process be to both encourage choice and maximize the rate of voluntary choice; and what kinds of outreach and education are necessary to ensure that beneficiaries understand how to access services in a managed care system. Assessing enrollment policies and practices can provide an informative "window" on the states' approaches to their Medicaid managed care programs and the roles played by various stakeholders including the state, plans, providers, beneficiaries, and community-based organizations and advocates.

### ***Research Methods for this Study***

This study examined enrollment policies and practices in states with mandatory Medicaid managed care programs with the following research goals: 1) to gain a better understanding of states' evolving enrollment policies and practices for their mandatory Medicaid managed care programs, 2) to assess the role played by enrollment in developing Medicaid managed care markets, and 3) to examine the experiences of Medicaid beneficiaries and of FQHCs as they are required to participate in MMMC programs.<sup>10</sup> A case study approach was used to examine closely enrollment policies and practices in nine states." This approach facilitated the focus on the enrollment-related experiences of beneficiaries and federally qualified health centers under mandatory Medicaid managed care programs. This emphasis on these two stakeholders is

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<sup>10</sup> This research was funded by the Center for Health Care Strategies, a Robert Wood Johnson Foundation-funded project, The David and Lucile Packard Foundation, the Kaiser Family Foundation, and the Health Resources and Services Administration Bureau of Primary Health Care (HRSA/BPHC).

<sup>11</sup> See Appendix A for more details about the study methods.

unique among existing enrollment studies and provides a compelling perspective for assessing the effects of enrollment.

This study was designed to examine how particular elements of the enrollment process influence the implementation of mandatory Medicaid managed care, shape the experiences of Medicaid beneficiaries as they leave a fee-for-service healthcare system, and affect the ability FQHCs to operate in a managed healthcare system. Thus, our research questions were:

- How are state enrollment policies and practices developing and evolving as mandatory Medicaid managed care (MMMC) programs are developing and evolving?
- What are the specific state autoenrollment policies and practices under MMMC programs? What role is played by these policies and practices within the states' enrollment policies?
- What factors related to the enrollment process affect the decisions and/or willingness of plans, either commercial or provider-sponsored, to participate in MMMC programs? Are states tailoring **enrollment/autoenrollment** policies to solicit the participation of plans?
- How are Medicaid beneficiaries affected by state **enrollment/autoenrollment** policies and practices, especially as these policies and practices affect their ability to choose providers as well as health plans? What are these beneficiaries' particular experiences with enrollment?
- How are federally qualified health centers (FQHCs), **affected** by state enrollment policies and practices? Have the FQHCs experienced a loss of Medicaid patients and/or revenues due to particular enrollment and autoenrollment policies and practices?

The process for selecting the case study states involved the careful analysis of numerous descriptive variables (e.g., autoenrollment rates, choice window, use of **enrollment** broker, how long MMMC implemented, PCCM or risk-based coverage, covered populations, FQHC experience with changes in patient volume and revenue) in the thirty-four states with significant mandatory Medicaid managed care activity. Based on this analysis, we initially proposed

eighteen potential sites to our funders and ultimately decided on these nine sites: California, Connecticut, Florida, Maryland, Michigan, Missouri, New Mexico, Oklahoma, and Oregon.

Preparation for the site visits involved extensive collection of background materials and background interviews with a range of state and federal informants. We sought the assistance of local experts to develop the lists of contacts and key informants. During three to four day site visits, structured interviews were conducted onsite with key informants in each state including state Medicaid officials, managed care plan officials, FQHC representatives, Medicaid beneficiaries, and community advocates. The protocols for these interviews were designed to collect systematically data relevant to the study questions; informants received copies of these protocols prior to the interview.

Two methods were used to assess the impact of enrollment and autoenrollment policies on Medicaid beneficiaries. One, the key informants were asked for their perspectives on beneficiaries' experiences. Second, two focus groups with Medicaid beneficiaries were conducted in each state. In four states, additional focus groups composed of minority beneficiaries (e.g., African Americans, Hispanics, and Asians) were conducted and, in three states, additional focus groups with HIV-infected beneficiaries were conducted. The protocols for the focus groups were also designed to collect systematically data relevant to the study questions. These data were analyzed across the sites to produce this report.

### *Overview of Study States*

Tables 1, 2, and 3 provide information about a variety of characteristics of the nine states and 10 study sites. As noted above, the nine states were selected to represent a range in terms of their Medicaid managed care programs including the types of population covered by mandatory

Medicaid managed care, length of experiences with both commercial managed care and Medicaid managed care, and the types of risk-based components. These tables also illustrate that the states evidence a wide range of socioeconomic and demographic characteristics.

The following discussion, while more detailed than the overview in terms of reporting on the data collected, is still relatively summary by necessity given the breadth of information and wide range of perspectives collected at all of the sites. Appendix B contains detailed site visit reports for each state and the review of these reports is encouraged for those who wish to gain more insights and information about a particular state or to review the more complete basis for our findings and implications discussed below.

The discussion is also supplemented by information presented in Tables 4 through 14. These tables are constructed as data-based analytic tool to highlight the major findings. The following issues are represented: enrollment policies and practices (Tables 4 through 6), enrollment broker (Table 7), beneficiary selection of primary care provider (Table 8), plan switching (Table 9), autoenrollment policies and practices (Table 10), plan participation in MMMC (Table 11), characteristics and experiences of FQHCs (Tables 12 and 13), and the experiences of enrolling beneficiaries (Table 14).

## **Enrollment Policies/Practices - What Did We Find and -What Did We Learn**

States generally used the same basic elements for enrolling Medicaid beneficiaries in managed care, such as choice windows, employing a broker to inform and enroll, and using enrollment packets. Table 4 illustrates these basic enrollment characteristics and shows both the similarities and differences among the states, although procedural similarities outweigh differences. However, we also found that states' enrollment policies and practices varied substantially with regard to the commitment of resources for outreach and education around the enrollment process and the level of effort expended to achieve high rates of voluntary enrollment. Oklahoma and Los Angeles County represent two ends of the spectrum in terms of resources committed to enrollment even accounting for differences in the size of their respective Medicaid programs. While it is difficult to represent qualitative information in a table, the final row entries in Table.4 summarize the salient substantive characteristics of the enrollment process.

Table 5 represents in more detail aspects of the states' outreach and education efforts associated with their managed care initiatives and shows the range of these efforts in terms of intensity and quality. The notable factors that varied across the states include the role and responsibilities of the enrollment broker, the extent to which community-based organizations (CBOs) were meaningfully involved in outreach and education, and how much time the states were willing to invest in preparing beneficiaries for the shift to managed care.

An important aspect of our research also involved examining how enrollment worked during "conversion" - the process whereby fee-for-service Medicaid was transformed into Medicaid managed care and existing Medicaid beneficiaries became plan members either by choice or by default. Table 6 illustrates certain characteristics of this process and also shows that

our study states represent a range in terms of how recently and how quickly they, had implemented mandatory Medicaid managed care programs. Our primary reason for this focus on the conversion period is that this is where the operation and effects of autoenrollment policies and practices would be most visible, significant, and potentially informative as the state must deal with establishing a new system, meeting administrative, regulatory and legislative demands, and ensuring beneficiaries' participation and as beneficiaries must deal with managed care usually for the first time.

### *Enrollment Characteristics*

As shown in Table 4, the amount of time allowed for enrollment - the so-called choice window because enrollment always involves choosing a plan - varied somewhat but was predominantly 30 days in length. Almost all states used a broker to administer the enrollment process and beneficiaries generally had a choice of at least two out of three methods for enrolling: by telephone, by mail, or in person. Four states used all three methods. Voluntary enrollment rates ranged from 26 percent to 100 percent. While states with shorter choice windows (Oklahoma, New Mexico, and Maryland) all have relatively lower voluntary enrollment rates, several states with longer choice windows had lower rates as well, most notably Florida.

Beyond these structural characteristics, however, the real differences among the states involved the substantive quality of the enrollment process. For example, the type and level of assistance beneficiaries received in enrolling and selecting a plan ranged from assistance provided by community-based organizations along with the enrollment broker in person and by telephone in Los Angeles County and Connecticut, to whatever limited help overloaded

caseworkers responsible for enrollment in Oklahoma could provide. The information beneficiaries could obtain regarding their plan choices prior to enrollment ranged from somewhat detailed information including provider panels in Maryland and Los Angeles County to very limited information and no identification of network providers in New Mexico and Oregon. States varied in the degree to which they offered telephone assistance or face-to-face assistance through community meetings, utilized the services of community organizations, and permitted health care providers to offer enrollment assistance to patients.

The use of CBOs is becoming more common as states recognize the value of using these entities to reach certain types of beneficiaries (e.g., harder to reach groups such as persons whose first language is not English or harder to serve groups such as persons with serious mental illness). Five states used community-based organizations to assist with enrollment although the terms of these arrangements varied with respect to the amount of resources committed to the CBOs, the amount of responsibility awarded to CBOs, and the level of training and oversight provided by the broker or the state. The approach to enrollment in Los Angeles County and Michigan illustrates a more intensive use of CBOs.

The role of individual health care providers in helping their patients select a plan and understand the implications of enrollment and selection for access to their regular source of care ranged from some ability to advise patients in Maryland and Michigan to an outright bar on provider communication in several states including Oklahoma, Missouri, and Maryland. Two states, California and Florida, permitted providers to furnish information regarding their plan membership to patients, while three states, Connecticut, Michigan and Oregon, permitted providers to assist in limited ways in the managed care enrollment process, either on a short-term basis during conversion or as a function of their Medicaid outstationed enrollment

responsibilities. A number of informants in various site interviews expressed concerns regarding the potential for providers to either “steer” patients toward, or actively discourage some individuals from enrolling in, certain plans in which they maintained ownership. Providers, on the other hand, frequently voiced concerns that enrollment assistance was the type of basic community service that their patients had come to expect. They indicated that patients were angry and frustrated over their inability to get this form of help, particularly in communities in which other information was perceived to be confusing.

Table 5 shows the range of state outreach and education efforts and also the extent to which the brokers have primary or shared responsibilities for these efforts. There is no apparent association/connection between this level of activity and the level of the voluntary enrollment rate. Whether or not CBOs are involved in enrollment-related activities seems to be associated with higher rates, but this is not consistent across all of the states. In addition, the intensity of CBO involvement likely affected the actual improvement in outreach to beneficiaries. For example, in New Mexico, CBOs reported receiving limited and adequate support from the state whereas in Los Angeles County the broker, at the direction of the state, is committed to extensive CBO involvement – these differences appear to be reflected in the voluntary enrollment rates.

All states prohibited direct marketing and presumably direct contact by participating plans with the notable exception of Florida where HMOs can engage in preenrollment interactions with beneficiaries and assist them with enrolling.\* Once again, Oregon is the outlier with 100% voluntary enrollment and moderate outreach efforts with no broker; this result is likely the result of “mandatory nature of voluntary enrollment.” Most states appeared to allow

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<sup>12</sup> This practice is coming under increasing scrutiny by state officials and others • the advent of the broker in Florida may bring this practice to a halt, especially given Florida’s history of abuse by managed care plans participating in Medicaid.

providers some ability to talk with their patients about the new managed care programs but concerns of state officials and advocates about provider abuse may create a chilling effect on these communications.

Most states had a fairly standard set of enrollment materials (i.e., letter explaining the need to choose and information about benefits and plans), and did spend time and resources to improve their enrollment packets. The notable exceptions are Florida and Oklahoma. As noted above as well as in Table 5, however, these enrollment materials usually lacked adequate information about providers and provider networks. This deficiency could be viewed as rendering all enrollment materials inadequate for the purpose of enrolling. Los Angeles County's laudable effort to provide this information resulted in a provider directory so large and detailed that it was almost impossible for beneficiaries to use. These difficulties highlight the importance of assistance during enrollment, preferably face-to-face, and preferably with someone the beneficiary knows and trusts.

The most notable difference among the states concerns the level of effort about outreach prior to start-up. Table 5 shows the extent and range of these start-up activities engaged in by the states, and to some degree, these efforts may have resulted in higher voluntary enrollment rates. A variety of reasons appeared to contribute to these differences and deficiencies, although speed of implementation was the most common factor.

### *Use of Enrollment Broker*

Most but not all states used enrollment brokers to perform some or all enrollment-related tasks ranging from total responsibility for all outreach and education to just handling the

enrollment process to being-involved in post-enrollment problem solving.<sup>13</sup> Table 7 presents information about the role and responsibilities of the enrollment brokers in the nine states. The degree of responsibility afforded the broker tended to related in part to the broker's past experiences and degree of professionalism as well as the amount of resources the state was willing to commit. In some states, such as Connecticut, Michigan and Missouri, brokers actively participated in the development of enrollment policies and practices. In just two states, New Mexico<sup>14</sup> and Oklahoma, the broker was involved in post-enrollment problem solving.

Brokers appear to contribute to improved **and/or** more effective enrollment procedures. States with the lowest voluntary enrollment rates, Florida and Oklahoma, did not use a broker although Florida is about to use a broker in an effort to improve voluntary enrollment. Similarly, Michigan is changing brokers in order to improve their enrollment experiences, and Connecticut officials attributed their high voluntary rate to the efforts of its **broker**.<sup>15</sup> Broker comments indicated that state support ranged widely and that brokers frequently did not have enough time and/or resources to educate beneficiaries about the enrollment process. Many brokers (e.g., in Oklahoma, Connecticut, and California) were very willing to work with state on improving enrollment policies. The comments of enrollment brokers in Maryland and California also evidenced an awareness that beneficiaries needed to know more about Medicaid managed care than just how to get enrolled in a plan.

States' experiences with brokers showed the evolving use of enrollment brokers with a range of broker responsibilities depending upon the states' commitment to establishing an effective enrollment process. In five states, the enrollment broker (or in the case of New Mexico

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<sup>13</sup> See Kenesson. M. (1997). *Report: Findings from the Survey of State Medicaid Managed Care Programs Regarding Enrollment*. Waterford, VA. November.

<sup>14</sup> New Mexico uses their fiscal agent to perform certain broker duties.

<sup>15</sup> Oregon did use a broker during initial implementation of the Oregon Health Plan.

the fiscal agent) was required to contract with community-based organizations as part of efforts to make enrollment process more effective. Although not shown in Table 7, the amount of broker accountability varied as well in terms of how much oversight the states sought to exercise and whether the broker was held accountable for specific outcomes such as achieving low autoenrollment rates. Oregon is unusual for having stopped using a broker because of budgetary considerations whereas Florida is just bringing in a broker for first time. New Mexico's decision to use their fiscal agent was the product of budget concerns although this entity has become quite involved in the enrollment process. These findings suggest that the role of the broker should be tailored to the particular needs of the state in order to achieve optimum results and that generalizations across the states are difficult to make.

### ***Initial Conversion Process***

States also differed in the amount of time they allowed for the initial conversion to mandatory managed care. Table 6 illustrates salient characteristics of the conversion process in the nine states. In some states, conversion occurred during a period as short as a few months while in others the period was as long as two to three years. States also evidenced substantial variability in terms of their flexibility to move more slowly in the event that beneficiaries appeared to be experiencing problems grasping the managed care selection process. States that implemented gradually on a regional basis (e.g., Missouri, New Mexico) or by type of population (e.g., Oregon) reported that they took these opportunities to learn from their mistakes and improve their processes - improvements in the initial voluntary rates are apparent evidence of these efforts.

The extent and quality of state efforts at outreach and education prior to establishing the new Medicaid managed care programs as well as quality of enrollment process were fundamentally affected by the speed of conversion. A review of both Tables 5 and 6 indicates that a few states were able to devote more time and resources to prepare for the conversion period whereas, as discussed above, many states were constrained by time. For example, Los Angeles County (albeit required by HCFA) spent time prior to the beginning of conversion preparing beneficiaries for the enrollment process and improving their enrollment materials. The process by which existing beneficiaries were converted also affected the tenor of implementation • when beneficiaries and stakeholders were confused and uninformed as in Connecticut and Maryland, initial enrollment was chaotic.

Not surprisingly, gradual approach to enrollment, which also allowed more time for preparation, was less likely to produce the myriad problems and stakeholder chaos that occurred during rapid enrollment (e.g., Oregon versus Maryland). Rapid approaches to enrollment resulted in pressing ahead with enrollment even though the plans had not finalized their provider panels (New Mexico) and in being unwilling or unable to suspend enrollment when serious problems were discovered (Maryland). A variety of informants in all states noted that state officials faced pressures to proceed expeditiously with announced timetables for implementing their managed care programs including the participating plans' needs for certain number of covered lives, state budget pressures to move ahead , and legislative expectations of immediate and/or impressive cost-savings in Medicaid.

### ***Management Information Systems -Necessary and Problematic***

Because Medicaid managed care involved two levels of eligibility • one for Medicaid and

one for plan membership - the enrollment process is complex and requires a timely and smoothly operating interface among the broker's information system, the plans' information systems, and the state's eligibility system in order to facilitate proper identification of prospective enrollees as well as the transmission of plan choices or assignments back to the state and out to the plans. Informants in most of the nine states (including state officials as well as health plan, provider, and broker representatives) indicated that, particularly during the early implementation/conversion period, information systems frequently did not operate well and interfaced even less well. These somewhat predictable information systems problems were exacerbated by the process of moving too quickly with enrollment without enough information and without the ability to stop and make needed corrections.

The overarching issue here is the absolute necessity for sophisticated and smoothly-operating management information systems (MIS) in order for the transition to Medicaid managed care to be accomplished. The extent to which so many of the problems encountered with converting from fee-for-service to managed care were related to MIS deficiencies, and resulting cascade of difficulties linked to inadequate systems, inaccurate information, and poor communication, can not be overstated. Maryland is a particularly compelling example of how good intentions with respect to linking beneficiaries with their prior and/or traditional providers were completely undermined by poorly functioning and inadequate data systems. Unfortunately, these necessary systems are usually beyond the reach of most state budgets.

Provider directories and/or information about plan provider networks are an illustrative example of a central problem that could easily be solved with the appropriate MIS. The extent that states attempted to provide this information, the hard copy provider directories supplied to beneficiaries were always either immediately out-of-date or soon to be out-of-date and were

difficult for beneficiaries to understand and use. A sophisticated MIS with easy electronic access could facilitate continual update and instant information for plans, beneficiaries, and providers during enrollment (this does presume face-to-face or telephone enrollment or beneficiaries' ability to access electronic database).

### ***Lack of Information about Provider Networks and Provider Panels***

As just noted, one of the most distinct casualties of the rapid approach to implementation and poor capacity of information systems was the availability of information about the plans' provider networks and provider panels. Although choosing their provider was consistently most important to beneficiaries, the conditions for choosing primary care provider (PCP) varied among the states as shown by Table 8. Los Angeles County and Maryland provided for PCP selection as an integral part of the enrollment process, Santa Clara County, Michigan, Missouri, and New Mexico encouraged PCP selection by requiring the broker or the plans to solicit selection, Connecticut and Oregon did not provide for PCP selection during enrollment, and the remaining two states, Florida and Oklahoma simply allowed PCP selection. The primary reported reason for states' reluctance to encourage choice of PCP during the enrollment period involved the concern that provider network information was likely not correct and beneficiaries would be choosing their providers and plans based on inaccurate information.

Despite the apparent general availability of PCP choice, and even in states where enrolling beneficiaries were strongly encourage to choose their PCPs, the ability to exercise this choice was undermined by provider network information that was frequently inaccurate (Maryland), inaccessible (Los Angeles County), simply not available (New Mexico), or not really available unless beneficiaries enrolled by phone and asked broker for information

(Michigan and Missouri). Again, Table 8 illustrates the incidence of these deficits in provider information. As noted above,, creating accessible and accurate provider directories presents a very serious challenge for states; sincere state efforts can result in the huge and overwhelming provider directories created for beneficiaries in Los Angeles and constantly outdated hard copies of directories. Electronically created and maintained provider directories seems to be the most appropriate strategy but would require making adjustments to the enrollment process to ensure that beneficiaries could access this information during enrollment (e.g., enrollment by mail would appear to be an inappropriate unless beneficiaries could all access computer terminals).

In addition, because enrollment policies and practices determine the process of informing beneficiaries, enrollment will 1) affect their initial choices of plans and providers, e.g., whether to “go mainstream” or stay with their traditional provider, as well as 2) determine their awareness about ability to switch plans and/or demand out-of-plan use to gain access to their traditional provider. Our findings indicate that, in many states, the beneficiary’s ability to choose a provider during enrollment is either 1) foreclosed because this choice is not available or 2) seriously compromised by a lack of information about plans’ provider networks.

Consequently, the reality of enrollment process as the gateway to providers for Medicaid beneficiaries combined with the fact that the enrollment process constrained beneficiaries’ ability to choose providers in many states illustrate the overarching and long-term implications of enrollment for safety net providers’ efforts to adapt to a managed care environment by developing survival strategies based on patient recruitment and retention. This issue is addressed below in more detail during the discussion of the experiences of federally qualified health centers

(FQHCs) in these nine states.

We did find that

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PCP whether due to autoenrollment or lack of information

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states, Connecticut and New Mexico, required plans to give new members a

their PCP.<sup>17</sup> In general, state policies required plan

PCP.<sup>17</sup>

easily within plan although there were scattered reports of an annual limit o

Switching plans to get the provider of choice is another matter, however, and

contrast, Oklahoma officials acknowledged that this approach, given their high autoenrollment rate, would be too labor-intensive and demand too much of their information systems for them to undertake successfully.

Michigan has taken somewhat more indirect steps to preserve patient/beneficiary-provider relationships. During the conversion of Michigan's managed care system from primary care case management (PCCM) to full-risk managed care organizations, the state allowed PCCM providers to automatically enroll their patients into the HMOs in which they elected to participate, in order to guard against disruption in care. The state then permitted newly enrolled members the option of switching plans. In effect, the state autoenrolled into an MCO all individuals under PCCM care and then permitted them to opt-out into a different plan within a certain time frame if they desired to do so. Observers believed that this approach minimized the potential for care interruption, at least to the extent that PCCM providers agreed to remain in Medicaid and join a MCO.

### ***Other Efforts to Correct Enrollment Deficiencies and Improve Choice***

Most state officials were concerned about the consequences of an inability to choose a PCP due to deficiencies in outreach and education and the enrollment process and undertook to make other post-enrollment opportunities available for beneficiaries (both autoenrolled and voluntarily enrolled) to correct errors in enrollment. The most notable was the use of liberal, post-enrollment switch plan/provider policies or the so-called "free-switch" policies.

As illustrated by Table 4, almost all of the states had a "free-switch" policy; that is, beneficiaries could switch plans at least monthly without cause. In four states, Florida, Michigan, Missouri, and New Mexico, beneficiaries can switch plans any time without cause.

Maryland and Oklahoma allowed only a single switch without cause within 30 days of enrollment although Maryland officials reported that they were “relaxed” about this requirement during the initial implementation of HealthChoice. Oregon is unique in that the state allows plan switching only for cause - there is no free switch. While Oregon originally provided for a 30 day free switch period in the early years of the Oregon Health Plan, the legislature recently decided that Medicaid beneficiaries should not have more ability to switch plans than commercial insurance beneficiaries and rescinded this policy.

Table 9 provides more detail about the conditions and circumstances of plan switching among the states. It is evident that it is easier to switch plans in some states (e.g., Maryland and Michigan) than in others (e.g., California and Connecticut) in terms of the procedures. It was difficult to get good data on rates of plan switching, largely because disenrollment rates usually include other reasons for a member leaving a plan, such as loss of eligibility. Moreover, as discussed below, it also appears that beneficiaries are not necessarily eager to engage in a lot of plan switching even when dissatisfied.

It is important to note that these policies are integrally related to plan lock-in policies, which are discussed in more detail below in the section on plans’ experiences in these nine states. Lock-in policies essentially determine when a plan member must have good cause in order to switch plans. State policies in this regard will be affected by provisions in the Balanced Budget Act of 1997 that provide the Medicaid beneficiaries enrolled in managed care have 90 days to switch plans and then they are locked-in for nine months.<sup>18</sup> To the extent that this option to correct enrollment mistakes due to lack of information will be constrained, it will be necessary

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<sup>18</sup> HCFA’s current interpretation of this provision - that beneficiaries will get a new 90 day period every time they switch plans until they switch back to a prior plan - is troubling to many state and plan officials as this interpretation represents potential endless switching and plan membership instability. January 21, 1998 letter from Sally Richardson to State Medicaid Directors.

for state to consider how to improve the availability of provider information. Moreover, policies that limit plan switching to good cause also mean that beneficiaries must be better informed about how to address their need for PCP choice and other problems with plans. Advocates and other community representatives reported their concerns that free switch policies represent a potential minus for beneficiaries in that they deal with plan problems simply by switching.

Our findings also suggest, however, that liberal switch policies create serious problems by affecting the very stability of plan membership and the managed care market that states sought to achieve through a rapid conversion process. Liberal switch policies also lead to delays in payments to plans and providers further exacerbating problems for already overburdened safety net providers. This issue will come up again in the section on plan experiences and is illustrative of one of the major implications of this research: the tension between policies designed to improve the enrollment experience and policies designed to build a managed care market.

### *Treatment of Special Populations During Enrollment*

While this issue was not a specific focus of our research, the treatment of special populations during enrollment did come up during a few site visits. It is important to note that only five of the nine states currently require the disabled population (i.e., SSI recipients) to enroll in managed care. This situation reflects the general fact that the some states are consciously taking their time to include disabled and persons with special needs in managed care while others move ahead rapidly with enrolling the entire Medicaid population. However, it is also true that the AFDC/TANF-related population includes persons with special needs such as persons with chronic illnesses and persons who are culturally isolated.

A few states recognized the particular difficulties that beneficiaries in certain categories might experience in dealing with mandatory enrollment in managed care. For example, Missouri exempted children with special needs in foster care from being enrolled using the standard process. Los Angeles County held back enrolling thousands of beneficiaries whose primary language was not English until the language-appropriate enrollment materials were prepared. Oregon and Oklahoma delayed including disabled beneficiaries (e.g., SSI recipients) under mandatory managed care until gaining experience with the presumably healthier AFDC/TANF-related populations.

In New Mexico, state officials attempted to address the enrollment needs of special populations by contracting with advocacy groups and community-based organizations to provide special assistance to their constituencies (e.g., persons with developmental disabilities). Despite this laudable intent, however, advocates reported that these contracts were arranged at the last moment and for relatively small amounts of money and that the state could not tell them how to contact these special needs individuals due to privacy constraints. These circumstances seriously constrained the efforts of these organizations although most overcame these constraints through their existing networks. The worst problem was the lack of information about provider networks that made it very difficult for persons to figure out how to pick a plan and keep their specialist providers. Persons with serious mental illness were reportedly disproportionately affected by these circumstances.

Informants reported a range of opinions regarding the state efforts to address language and cultural issues in enrollment procedures and materials. Again, the increasing use of community-based organizations reflect an interest in making enrollment more culturally accessible. Table 8 illustrates that most states attempted make enrollment materials available in

other languages with varying degrees of success. One of the more unusual vignettes involving cultural issues concerned New Mexico's enrollment provisions that Native Americans were entitled to opt out of managed care in order to remain in the fee for service system under the Indian Health Services by so notifying the state. Apparently in certain Navajo languages, the term "opt out" loosely translated means "to die". As a result, Native American families received notices telling them that if they did not want to remain in managed care, they would have to "die." The state was unable to supply data on the number of Indians who did elect to opt out.<sup>19</sup>

Finally, in three states, Maryland, Missouri, and Oregon, we examined closely enrollment procedures for HIV-infected Medicaid **beneficiaries**.<sup>20</sup> We found in all three states that additional support, most commonly in the form of case management services, was available to assist these beneficiaries in the transition to managed care. While the effectiveness of this support did vary, it was evident that the case management-type assistance was valued by both the HIV-infected beneficiaries as well as the plans for maintaining continuity of care and addressing complex specialist needs. The presence of advocacy groups and CBOs knowledgeable about HIV/AIDS issues was also an important resource.

### ***Knowing How to Enroll Versus Knowing About Managed Care***

The issue of dealing with lack of PCP choice and other problems with managed care in ways other than plan switching raises important questions about the outreach and education efforts associated with the enrollment process. Across all nine states, informants from all groups

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<sup>19</sup> Serious financial losses experienced by Indian Health Service facilities that serve New Mexico's Native American residents but do not participate as risk-bearing managed care organizations as a result of federal legal prohibitions suggest that few if any Native Americans exercised this option.

<sup>20</sup> These findings are addressed in the section on beneficiaries experiences below as well as in the site visit reports. They will be reported in more detail in a separate report.

pointed out the distinction between knowing how to enroll versus knowing how to navigate the managed care system and suggested that there were serious deficiencies in beneficiaries' knowledge about how to use the managed care system. Most states' efforts were limited in terms of their focus on just the enrollment process and not on how to use managed care. Although this issue will be addressed in more detail in the section on beneficiaries' experiences in the nine states, it was apparent that another casualty of a poorly-supported and not well-structured enrollment process is the ability to educate beneficiaries about managed care generally. As discussed above with respect to the enrollment broker, informants as well as beneficiaries were aware that education about managed care was lacking placing even voluntarily-enrolled beneficiaries at a disadvantage. The potential for ongoing, post-enrollment education appears limited as states' Medicaid budgets are tight; a broker representative for Los Angeles County reported that post-enrollment cuts in her capacity are already set.

### ***Common Problems and Deficiencies Driven By Similar Budget and Market Concerns***

Although higher rates were frequently associated with greater commitment to achieving voluntary enrollment, there were no definitive patterns. Most states struggled with problems resulting from chaotic initial periods of implementing new systems too rapidly and associated inadequacies in state data and management information systems. On the other hand, our findings suggest that several states are taking steps to improve their enrollment process by using community-based organizations to enhance face-to-face enrollment, by expecting more from their enrollment brokers, educating all stakeholders about enrollment process, and by using a more gradual approach to establishing the new program such as where implementation occurs by

region within a state. We found evidence in Missouri, Los Angeles County, and Connecticut that these efforts can improve at least beneficiary choice, if not knowledge.

Our findings also suggest that many informants/stakeholders in the enrollment process understood the potential importance of enrollment beyond just being a mechanism for beneficiaries to enter a new system. Efforts to improve states' voluntary enrollment rates could result in beneficiaries, as well as state agencies, providers, and plans, being able to gain the much-touted benefits of managed care: plan members using services wisely and pursuing the use of preventive services with providers and plans dealing with better-educated patient/plan members able to responsibly participate in taking care of their **health**. One state's experience does raise a caveat about a narrow focus on improving the voluntary enrollment. By requiring Medicaid/Oregon Health Plan applicants to choose a plan as part of the application, and refusing to process applications without a plan selection, Oregon has achieved a voluntary rate of 100 percent. However, applicants must choose a plan without any information about plan networks and with limited information about how to use the OHP managed care system; in this situation, the high voluntary enrollment rate does not apparently mean informed choice by enrollees or high level of knowledge about using managed care.

Despite the awareness of how to improve enrollment, however, we found that the procedures for introducing Medicaid beneficiaries to the new system of care were frequently compromised by a conversion process characterized by too rapid change, inadequate support systems, poorly prepared participants, and an unwillingness by states to slow the process and make substantial corrections. This result may be due to the conflict inherent in an enrollment process that must address both beneficiary needs and plan/market needs. In other words, many of the desirable characteristics of an enrollment process designed to achieve high rate of

voluntary enrollment, informed choice, and knowledge about managed care (e.g., lengthy choice windows, extensive information about plans and provider networks, and intensive, face-to-face choice counseling) could impede rapid establishment of a stable market through the guaranteed enrollment of large bloc of covered lives, with few administrative burdens on participating plans to deal with new members' plan and provider preferences.

Our findings also suggest that voluntary enrollment rates alone are probably not an informative indicator of enrollment outcomes. As evidenced by experiences in Oregon and Connecticut, high voluntary choice rates may not represent the achievement of *informed* choice or the attainment of substantial knowledge about the system into which beneficiaries are voluntarily enrolling. On the other hand, in states with lower rates of voluntary choice, it may be equally important to ask about post-enrollment activities designed to correct pre-enrollment problems and errors. Once, whether voluntarily or involuntarily, beneficiaries can still be educated about how to use system and be given additional opportunities to choose plans and providers through liberal switch policies. These considerations may also require a reassessment of autoenrollment policies and autoenrollment rates.

### ***The Role and Features of Autoenrollment Policies -Another Perspective on Enrollment***

A state's autoenrollment rate could be viewed as a measure of how well the process of voluntary enrollment is working and how knowledgeable enrollees are about managed care. Indeed, a very low autoenrollment rate arguably indicates a great success in this regard such as might be claimed by Oregon reporting an autoenrollment rate of zero percent. However, as the foregoing discussion about enrollment demonstrates, in the absence of a **full** understanding of the enrollment dynamics, the autoenrollment rate may not be an informative indicator. Simply

forcing the elimination of autoenrollment will probably not achieve the desirable goal of voluntarily enrolling informed and knowledgeable beneficiaries.

The obvious relationship between **voluntary** enrollment and autoenrollment suggests that strategies designed to increase voluntary enrollment rate will of course work to decrease autoenrollment rate. But autoenrollment policies and practices also represent potential tools for the states in developing the managed care market (e.g., how autoenrollment lives are distributed among plans can determine which plans will thrive). Consequently, goals of autoenrollment policies, dependent upon a certain number of autoenrolled lives to be effective, may be at odds with the goals of voluntary enrollment.

Table 10 illustrates the salient characteristics of each state's autoenrollment policies and practices. As with enrollment, there is variability among the states with respect to the structural elements including: choice windows, how the autoenrollment rate is calculated, how autoenrolled lives are distributed, and efforts to "correct" autoenrollment-related errors. The **autoenrollment** rates ranges from zero percent in Oregon to 74 percent in Florida; several states reported relatively high autoenrollment rates including New Mexico, **Oklahoma**, and Michigan. The state was almost always responsible for identifying and distributing autoenrolled lives. While few states attempted to match nonchoosing beneficiaries with providers, most states employed fairly liberal plan switch policies.

While the length of the choice windows is not necessarily a good predictor of the level of the autoenrollment rate (e.g., shorter choice window means higher autoenrollment rate), greater efforts expended during enrollment to get beneficiaries to enroll voluntarily seem to be associated with lower autoenrollment rates. In Connecticut and Missouri, the enrollment process involved several phone calls and reminder notices to the beneficiaries while in Florida, New

Mexico, and Oklahoma, the enrollment process involved one mailed notice. Broker representatives in Connecticut, commented that the phone calls made a big difference in the enrollment rate.

Table 10 also shows that six states used autoenrollment policies to achieve certain enrollment and managed care market goals.<sup>21</sup> In Los Angeles and Santa Clara Counties, California, the establishment of the two-plan model depends upon the initial award of all autoenrolled lives to the public plan otherwise known as the local initiative. In Michigan, Missouri, New Mexico, and Oklahoma, autoenrolled lives are awarded to plans based on how well they score during the competitive bid process. In Oklahoma, state officials also initially favored the state university-sponsored plan with more autoenrolled lives and in Michigan, only a certain number of plans in each region will receive autoenrolled lives. Moreover, in New Mexico, plans continue to be scored each year to determine the distribution of autoenrolled lives; plans with high EPSDT screening and childhood immunization rates receive higher scores.

As discussed above, Florida is using autoenrollment policies to shift beneficiaries from one system (PCCM) to another (full-risk managed care) and to minimize disruption in care. Florida also requires plans receiving autoenrollees to make extra efforts to contact these members and disenrolls autoenrollees if no provider-patient contact has occurred within four months of enrollment.<sup>22</sup> Oklahoma autoenrollment policy also includes “take back” provisions - if a plan has not made contact with autoenrolled plan members within 90 days, these enrollees are reassigned to a safety net provider which may or may not require a plan switch.

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<sup>21</sup> A seventh state, Connecticut just recently eliminated its policy of awarding autoenrolled lives to the two highest scoring plans in favor of random assignment of lives among all participating plans.

<sup>22</sup> In light of the fact that plans are receiving reduced payments during this 4-month period, it is unclear why any plan would make an aggressive effort to encourage **autoenrolled** persons to obtain care as opposed to keeping them enrolled for the 4-month minimum until they are disenrolled.

While few state officials were willing to acknowledge explicitly the role played by their autoenrollment policies, these various state approaches reflect substantial policy goals related to the development of managed care markets. For example, limiting the award of autoenrolled lives to a limited number of plans results in managed care markets that consist of a few large companies rather than many smaller ones. The preferences given in California and Oklahoma facilitate the development of managed care organizations operated by state or locally funded health care providers, such as academic health centers or public hospitals or health agencies. In Florida, autoenrollment policies are clearly being used to replace the PCCM market with an HMO market. Finally, awarding autoenrolled lives based on plans' competitive scores achieves two goals: saving money and providing incentives for good performances by plans.

On the other hand, states such as Missouri, California, and Maryland reported using the level of autoenrollment rates as measure of broker performance in managing the enrollment process. The Health Care Financing Administration used the relatively high level of autoenrollment as the basis for halting implementation of two-plan model in California. In Maryland, in accordance with the HCFA-dictated terms of its §1115 waiver, the state had to take corrective action when the autoenrollment rate exceeded 40 percent. These findings suggest that autoenrollment is a complex and not easily-categorized phenomenon that can reflect different aspects of the multi-dimensional nature of enrollment.

Finally, the desirability of autoenrolled lives was not always clear-cut. Plans may desire autoenrolled lives because of beliefs and perceptions that these lives are cheaper although there

is little empirical evidence for this proposition and none offered during this study.<sup>23</sup> It is more likely that the interest in autoenrolled lives is premised in plans' concerns about developing place in market. Several managed care plan informants noted that as a general matter, high volume mandatory enrollment generally can heavily influence the size and stability of the Medicaid market. On the other hand, while these study findings indicate that most states used autoenrollment to achieve certain policy goals deemed important to the overall success of their systems, most plans and states did not indicate that autoenrollment policies and practices were the driving policy in developing their strategies either to participate in or establish mandatory Medicaid managed care programs.

The goals that underlie state autoenrollment policies and practices often are important to the overall structure and stability of the health care system. These goals also may help clarify why a large number of autoenrolled lives may be problematic from a beneficiary choice point of view but potentially beneficial to the overall system of care from a state's viewpoint or that of the market. Assuming that post-enrollment corrections can be carried out in a manner that is not disruptive, then state policy makers might rationalize that the goals of price efficiency and market development are at least as important as front-end informed choice and thus might not see high autoenrollment rates as a problem. Indeed, in most states that were able to report data, post-enrollment voluntary switch rates were generally so low that the actual disruptive effects of permitting liberal switching would appear at first blush to be quite limited. In fact, however, as discussed in the following section on plan participation, post enrollment switching policies create serious consequences of their own.

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<sup>23</sup> There are no data on whether autoenrollees are less expensive than other managed care enrollees. See generally: Maloy, K.A., Rosenbaum, S., et al. (1997). However, because weeks may elapse before autoenrolled persons are made aware of their particular plan membership, common sense would suggest that autoenrollees may in fact cost less. The Florida and Connecticut approaches would appear to **confirm** this, although in neither state did there appear to be data to back up these assumptions.

## Experiences of Health Plans Under State Enrollment Practices

We wanted to examine whether and how enrollment policies and practices might affect plan participation, and if so, how states might be manipulating these policies in order to secure plan participation in their mandatory Medicaid managed care programs. This inquiry also facilitated consideration of the other major role of the enrollment process: the creation of managed care markets by making covered lives available to plans.

Table 1 illustrates the salient characteristics of the plans participating as well as of plan participation in the nine study states. Substantial variability among the states is evident with respect to the number and type of participating plans, how plans are selected, how **capitation** rates are determined, and potential incentives for participation.

We considered two categories of enrollment policies and practices that might affect and/or encourage plan participation. The first category involves autoenrollment policies, specifically the state's approach to distributing autoenrolled lives. As **discussed above**, our findings suggested that, while preferred assignment of autoenrolled lives was of some interest to the plans, these autoenrollment policies were not the overriding factors in plan participation. While, plans were generally eager to respond to autoenrollment-related incentives (i.e., award of autoenrolled lives related to competitive bid scores), autoenrollment-related concerns were not paramount. In addition, states appeared to be equally interested in supporting particular types of plans (e.g., public plans in California or full-risk **HMOs** in Florida) with these policies as opposed to just encouraging overall commercial plan participation. Indeed, commercial plans were frequently unhappy and frustrated with the support for public plans through preferred distribution of autoenrolled lives, which they perceived as placing them at a disadvantage in the

market, and/or with the requirement that they get involved with the procedural aspects of ensuring additional reimbursement for certain safety net providers.

The second category involves policies designed to stabilize plan membership including provisions for plan lock-in and for periods of guaranteed eligibility. Again, as discussed above, while five states had some type of lock-in policy, namely Maryland, Michigan, New Mexico, Oklahoma and Oregon, all but one of these states had at least a 30-day period for switching plans without cause. The remaining four states had policies that allowed plan switching to occur anytime without cause. With respect to guaranteed eligibility, Table 11 shows that just three states, Maryland, Oklahoma, and Oregon, had policies guaranteeing six months of eligibility although plan informants in both Maryland and Oklahoma reported that these policies were not implemented in a manner necessarily beneficial to the plans. Connecticut and Florida officials reported that they are planning to institute six month guaranteed eligibility in July 1998 although in Florida this policy is limited to **children**.<sup>24</sup> Consequently, our findings seem to suggest that these policies are not seen as representing important incentives for plan participation.

We also found little evidence that states had a **difficult** time getting plans to participate in their Medicaid managed care programs — these circumstances may explain the lack of importance afforded to enrollment policies as incentives. Plan officials in several states reported that the general guarantee of large blocs of covered lives associated with mandatory managed care was the important factor in their participation. However, many plan representatives as well as some state officials raised concerns about the ongoing participation of large commercial plans. For example, Connecticut, Oregon, and Missouri have all experienced the loss of major

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<sup>24</sup> The BBA permits states to guarantee 6 months' enrollment to any managed care organization enrollee regardless of the federally qualified status of the member's MCO and also gives states the option to **guaranteed** eligibility for children under 19. Section 4709.

commercial plans from their Medicaid programs. Company withdrawal from Medicaid managed care due to a variety of reasons, including low Medicaid **capitation** rates and higher than expected costs, is becoming front page news in many states. <sup>25</sup>

However, while these nine states were not experiencing difficulties with participation in Spring 1998, our findings did show that plans were uniformly troubled about two enrollment-related issues: 1) challenges presented by the unstable enrollment patterns of their Medicaid members including fluctuating eligibility and short eligibility periods, and 2) fewer than expected covered lives caused by falling Medicaid rolls. Most plans reported losing money for longer periods than expected. Plans were also becoming increasingly frustrated with the administrative burdens associated with Medicaid managed care including having to deal with either better-educated and more choosy enrollees or less-educated and emergency room-using enrollees. As a result, the states' willingness to use enrollment techniques that slowly build a base of informed decision-making may decline if such techniques are seen as incompatible with achieving plan participation and thus maintaining market control.

Escalating monetary losses and increased competition for Medicaid lives have heightened plans' enrollment concerns, particularly regarding the consequences for stable plan membership of states' liberal plan switch policies to compensate for poor enrollment procedures. A number of plan representatives voiced concerns about post-enrollment switching. While the number of voluntary switches appears to be quite low in most states, plans reported that the potential for switching in the early months of managed care enrollment led some states to not make payments to the plans during the first portion of the enrollment period and led plans to delay contacting

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<sup>25</sup> See: National Public Radio Morning Edition piece September 18, 1998 by John Hamilton referring to study by Robert Hurley examining plan withdrawal from Medicaid managed care programs. See also Peter Kilbqm, "HMOs Are Cutting Back Coverage of the Poor and Elderly," *New York Times* July 6, 1998.

new plan members. These payment and service delays frequently led to serious financial problems with the plans as well as their providers and may have effectively ensured low levels of service to new members, thereby potentially (and ironically) prompting more plan switching. As the Medicaid market continues to shrink in terms of covered lives, and as plans grapple with unanticipated challenges, states will likely face increased pressure to modify certain aspects of their enrollment procedures to encourage plan participation. Liberal post-enrollment plan switching and the disproportionate award of autoenrolled lives to public plans run counter to the plans' desire for the stability and predictability of the commercial market.

The market pressures on state agencies to maintain their bargaining leverage in creating a market by purchasing care in large, stable blocs were also evident from the findings. State officials in New Mexico and Maryland, concerned about both the plans' need for a certain number of covered lives within a certain period of time and their own promises of cost savings through managed care, pursued a strategy of rapid, large-scale implementation — sometimes before contracts with plans were even finalized and provider networks in place — with inadequate provisions for enrollment education. High rates of autoenrollment represented an acceptable price, and frequently a valuable bargaining tool for attracting plans, for such responses to market pressures.

In Los Angeles County, the pressure to create a competitive supplier market resulted in such a complex and multi-layered managed care system that conveying accurate and understandable information to enrolling beneficiaries may have been effectively impossible. Other states' efforts to stimulate the rapid creation of a managed care market instead created enrollment processes so bereft of information about provider networks, particularly specialists, that the inevitable results were the excessive and detrimental autoenrollment of culturally

isolated and seriously disabled individuals into plans with inappropriate (and in some cases, non-existent) provider networks.

Both states and plans are dealing with implications of the changing populations in Medicaid program as well as the conflicting demands of developing and/or participating in the Medicaid market. The states' efforts to correct the lack of choice in enrollment by establishing liberal switch policies represent a compelling expression of this conflict as the ultimate effect of these policies is to destabilize plan membership and create unattractive market conditions for plan participation. It is also evident that, because the circumstances of the Medicaid market are changing, the conditions conducive for plan participation may be changing as well and these findings about the experiences of managed care plans under state enrollment policies may become less informative.

## Experiences of Federally Qualified Health Centers Under State Enrollment Practices

Federally qualified health centers (FQHCs), which provide health care to low income, residents of medically underserved communities and discount their charges in accordance to ability to pay, account for a disproportionate amount of uncompensated primary care in the areas in which they are located. In 1996, the federally funded health centers located in the study states provided care to approximately 2.1 million persons, approximately 45 percent of whom were uninsured, and 30 percent of whom were Medicaid recipients.<sup>26</sup> Although there was substantial variation among these centers depending on their size and location, the overall average percent of their revenues derived from Medicaid for that year was approximately 35%. Because of the poverty of their patients and their high degree of reliance on Medicaid, health centers have much to gain or lose from changes in state Medicaid policy related to the establishment of mandatory Medicaid managed care programs. The consequences for FQHCs of this shift to managed care will likely be substantial.

Consequently, we sought to examine the enrollment-related experiences of FQHCs during and after the transition to Medicaid managed care in order to determine how well FQHCs were able to deal with the shift and whether they experienced substantial changes in the numbers of their Medicaid patients and amount of revenues. We anticipated the potential for significant losses of patients due to enrollment problems, especially high autoenrollment rates, and corresponding drops in Medicaid revenues. While our findings do suggest that enrollment policies and practices have substantial effects on FQHCs that involve the loss of patients and

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<sup>26</sup> The results from a recent CHPR-conducted survey of insurance patterns among FQHC patients in New Hampshire suggest that those with Medicaid may experience only brief periods of coverage and may otherwise rely on their health center for subsidized care.

revenues, the attribution of these effects to particular enrollment policies and/or practices was generally difficult, if not impossible, however, because of serious deficiencies in most FQHC data and MIS systems as well as the presence of other influential environmental factors such as falling Medicaid rolls. On other hand, we found that particular aspects of managed care financing structure also affected FQHCs. Consequently, because it is important to distinguish between the enrollment-related effects and the financing-related effects of the shift to mandatory Medicaid managed care due to the potential for different implications for FQHC and other safety net providers, we discuss the findings in these two areas separately.

### ***FQHC Characteristics***

Table 12 shows the characteristics of FQHCs across the nine states and illustrates the range of characteristics captured through the site selection including the number and size of centers, annual revenues, and changes experienced from 1995 to 1996 in terms of Medicaid and uninsured users. For example, the change in the number of uninsured users increased by 32 percent in California, increased by 13 percent in New Mexico, decreased by 29.6 percent in Connecticut and decreased by 27 percent in Oklahoma. The change in the number of Medicaid users increased by 17 percent in California, increased by 13.9 percent in New Mexico, decreased by 34.2 percent in Connecticut and decreased by 59 percent in Oklahoma. Table 12 also shows that there are not many FQHC-sponsored plans in these states and that FQHC-sponsored efforts to develop integrated services networks ( ISNs) are underway in all states.

In each state, we attempted to interview a range of FQHCs — urban and rural, large and small, new and old. Our data reflect a wide range of FQHC experiences that are not easily summarized but are probably accurately indicative of the real-world variation both across states

as well as within states on these issues. It became apparent that, while there were some important commonalities, each state, and frequently each FQHC, provided a unique story about their experiences under Medicaid managed care.

As shown in Table 13, reports of loss of Medicaid patients and revenues varied from greater than 25 percent (substantial) to less than 10 percent (some). There were no obvious patterns in the reported loss of patients with respect to enrollment or FQHC characteristics. These losses could be attributable to particular enrollment policies or to the inevitable problems with implementation. For example, in three states where implementation of the new programs was just or recently completed, reports varied from Maryland where patient loss was high and consistent across all reporting FQHCs to Michigan where reports of losses varied to New Mexico where patient loss was not substantial across reporting centers. For states where managed care programs were not so new, FQHCs in Florida reported a steady erosion over several years whereas FQHCs in Oklahoma reported continuing substantial patient losses. There seemed to be little correlation with autoenrollment rates as the FQHCs in states with comparable and relatively high rates — Michigan, Maryland and New Mexico — reported different levels of loss.

Other reported factors that could have contributed to reported patient losses included Medicaid patients choosing to go “mainstream”, center overcounting of prior patients, and inadequate data systems. While there were states that reported significant Medicaid patient loss, notably Maryland, New Mexico, Oklahoma, and Florida, the contributing factors to patient loss, such as initial enrollment chaos associated with a rapid implementation, evidence of patients choosing to go elsewhere in response to health plan marketing and choice, and the FQHCs’ continued inability to document their experiences with data, make it difficult to conclude for these states that systematic mistakes in enrollment were the primary factors in patient loss.

Moreover, the two California sites as well as Oklahoma also illustrate the increasingly common scenario where all plans and providers participating in Medicaid managed care are losing patients due to the overall reductions in Medicaid rolls.<sup>27</sup> Finally, experiences also varied by FQHC type — small/large, rural/urban, new/old, and experience with managed care. No strong patterns associated with patient and revenue loss emerged although occasionally larger centers with more funds available to develop expertise were better able to figure out how to keep patients. A few centers that reported initial patient losses also reported a slow but steady return of their patients after a couple of years of operating under mandatory Medicaid managed care.

### ***Loss of Patients -Significance of Provider Information and Education During Enrollment***

Because enrollment policies determine entry to managed care system, any substantial enrollment problems affect the ability of FQHCs to get and retain patients. As noted in the earlier discussions associated with Tables 5 and 8, the lack of accessible and accurate provider information was/is a very common occurrence and results in a range of problems found in all states. Beneficiaries reported substantial trouble in choosing or finding a plan with their FQHC provider; confusing enrollment materials meant that beneficiaries could not identify how health centers and their staff were identified in PCP lists when these lists were available. Center respondents uniformly noted the absence of accurate provider information as well as the absence of any information in some states during enrollment.

Center respondents also reported problems with policies barring communication with

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<sup>27</sup> Maryland and California represent two different efforts to ensure that FQHCs/traditional providers would receive substantial numbers of patients under mandatory Medicaid managed care programs. In Maryland, the historic provider protection was apparently poorly implemented due to serious problems with state data systems and consequently was of little help to FQHCs. In California, the two-plan model is still in the early stages of being established in some counties and the effects for FQHCs are being confounded to a certain extent by the dropping Medicaid rolls and by patient choice/switching.

patients and the difficulties creating for helping/insuring that their patients could and would make plan/provider selection. Inadequate education about the managed care systems meant that FQHC patients did not understand about importance of choosing; poor information about system during enrollment meant that patient may 'go mainstream' and not know about loss of FQHC access. Health centers' enrollment-related problems largely centered on the lack of any, or in some cases any accurate, information during the enrollment phase in the membership and composition of provider networks.

Many center respondents noted that, to the extent they were losing patients during the enrollment or provider selection phase to other plans or providers, this was occurring, not because their patients were knowingly "deselecting" them, but because in many cases their patients did not understand that remaining with the health center was an option. Provider membership information, when available, nearly always identified PCP members by their individual names rather than the name of the clinic in which they practiced or with which they were affiliated. Patients were thus left with the impression that centers were not network participants when in fact they were. Ironically, even as enrollment policies in states such as California and Connecticut encouraged the informal provision of information to patients by providers, their broker and plan contractors were conveying the names of the **PCPs** in different formats. Provider materials frequently displayed **PCPs** by their individual names only evidencing a serious lack of awareness of how to connect patients with FQHC providers in order to facilitate choice. Even where health centers and their association representatives attempted to correct misleading or non-existent information, informants reported that their efforts often were fruitless due to MIS problems and limitations such as were reported in Maryland and New Mexico.

Center respondents in some states also noted that the limitations placed on their pre-enrollment activities by the state carried serious consequences. While the nine states did not appear to prohibit uniformly the communication of factual information (e.g., the list of plans with which the center was affiliated), almost half of the states — Oregon, Michigan, Connecticut, and California, and most advocates were very concerned about providers potentially having undue influence on beneficiaries’ choice of plans. These attitudes seemed to have a chilling effect on the ability of FQHCs to respond adequately to patients’ requests for assistance with enrollment. Moreover, the centers’ ability to supplement the provider information available to the patients appeared to be hampered by the fact that, although a center might identify itself by its organizational name, the enrollment brokers and plans had no means of translating this information into a selection.

Finally, beneficiaries’ lack of information about provider networks combined with their probable lack of understanding about their entitlement to FQHC services could have significant consequences for both FQHCs and beneficiaries. States are reportedly being allowed to address this entitlement by either requiring all plans to have at least one FQHC in their network or giving beneficiaries a choice of plans where at least one plan has at least one FQHC in its provider network.<sup>28</sup> However, without FQHC provider network information, which FQHCs could provide to their patients, beneficiaries could be unknowingly waiving their entitlement by choosing a plan without an FQHC or choosing a plan with an inaccessible FQHC. If the incidence of this uninformed “waiver” is high, FQHCs could disproportionately lose patients and/or provide substantial out of network services that plans won’t be required to reimburse.

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<sup>28</sup> Federal Medicaid law requires that FQHC services, like EPSDT services, must be made available to Medicaid beneficiaries; this requirement may be waived under § 1115 waivers but not under § 1915(b) waivers. Where required and not waived, HCFA has allowed these two approaches to satisfy entitlement even where the single FQHC in a plan’s network might not be accessible for all plan members.

### *Potential Financial Disincentives for Plans to Assign New Members to FQHCs*

Several FQHC representatives in states such as New Mexico, Missouri, Maryland, and Oklahoma reported that the systematic problems experienced by beneficiaries trying to locate and select their PCPs reflected a deliberate strategy to make it more difficult for beneficiaries to elect to remain with centers as their prior providers. FQHC representatives asserted that state officials and plan representatives had financial incentives to break this existing provider-patient link. In those states in which the plans were under a contractual obligation to make cost-based supplemental payments on states' behalf, plans could avoid paying higher prices by not assigning new members to centers.<sup>29</sup> Similarly, states might face fewer requests for cost-based reimbursement (CBR) from FQHCs if they are serving fewer Medicaid patients.

We found no independent evidence, however, that state officials and plan representatives were actively discouraging patient assignment to FQHCs. However, this probably unfounded perception is important to recognize as this may be a reflection of the arms-length relationships between centers and state agencies and plans. On the other hand, many centers asserted that the special FQHC payment rules were more of a hindrance than an aid. While centers did not dispute the need for funding for their uninsured patients, many saw the FQHC methodology as contrary to their ability to fit into a competitive market and as a means of encouraging inefficiency at a time when centers must learn how to identify and solicit new funding streams.

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<sup>29</sup> Indeed, many FQHC respondents report that they want to be “invisible” providers in Medicaid managed care programs. These representatives don’t like the various state approaches of giving plans higher cap rates that are supposed to be passed on to FQHCs or other kinds of special incentives for higher FQHC payment rates because these administrative burdens can discourage plans from dealing with FQHCs as providers. These representatives assert that direct payments to FQHCs from the states are much better approaches to providing the necessary funding for enabling service and services to the uninsured.

### ***Revenue Losses and the Retention of Cost-Based Reimbursement: Importance of Maintaining and Developing Funding Streams***

As Table 13 illustrates, the FQHCs in the nine states reported experiencing losses in revenues and these losses varied in amount and significance. It is important to note the pattern associated with waiver of cost-based reimbursement (CBR) under § 1115 managed care demonstration programs in Maryland, Oklahoma, and Oregon. In these three states, FQHC respondents uniformly reported substantial losses. In the remaining states, where the operation of a § 1915(b) waiver meant that CBR could not be waived, center respondents generally reported minimal losses.

Consequently, in those **three** states where CBR was waived with no alternative form of transition **payments**,<sup>30</sup> the FQHCs are facing very serious financial struggles. The retention of CBR does not necessarily forecast certain short-term financial respite for FQHCs. In Florida, the methodology for making CBR payments is still unresolved and, as a consequence, centers reported ongoing troubling revenue losses. In Connecticut, the recent resolution of CBR issues has meant significant financial relief for FQHCs that had been facing more serious financial losses under Connecticut Access. Other CBR-related issues with which FQHCs and state were grappling included: 1) how frequently CBR reconciliation would be made (i.e., monthly, quarterly or annually), 2) would the state remain directly responsible for CBR payments or could plans function as **pass-throughs**, and 3) ongoing questions about the rules for allowable costs. The resolution of all of these issues has financial implications for FQHC survival under managed

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<sup>30</sup> Oklahoma provided transition payments but they were viewed as so minimal as to be insulting – see Table 13.

care.<sup>31</sup> However, in states where CBR payments are continuing without serious dispute -New Mexico, Michigan, Missouri, and California — the FQHCs are not experiencing serious financial problems right now. On the other hand, all FQHC respondents are well aware that CBR is slated for extinction in 2003 and that other financial solutions and/or supports must be forthcoming.

In the absence of CBR payments, the payment rates for FQHCs negotiated and/or established under Medicaid managed care are generally inadequate to support the traditional approach of FQHCs to providing services both to Medicaid patients and uninsured patients. Although FQHCs are at various early stages in their ability to document with data the exact parameters of these inadequacies, the basic tenets of managed care financing clearly foreclose payment rates that will account for the provision of enabling services or services to the uninsured • services that are not otherwise “covered.” In addition, FQHCs often reported that they agreed to inadequate payment rates and didn’t pursue aggressive financial negotiations in order to maintain favorable relationships with the plans.

Moreover, it is also important to note that the serious revenue losses experienced by FQHCs are really due to reduced payment rates and not to patient losses. For example, it is apparent in Maryland that, even if the FQHCs had not lost any patients, the drastic cuts in rates as well as loss of enabling funds and CBR would have still resulted in substantial revenue losses for the FQHCs. We see this similar dynamic in Oregon, another state where the drop in revenues was not cushioned by CBR payments, where centers who report getting more Medicaid patients

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<sup>31</sup> In an April 20, 1998 letter to state Medicaid Directors, Sally Richardson discussed the requirements of the BBA related to the reimbursement of FQHCs and Rural Health Clinics (RHCs). States are required to make these supplemental CBR payments on at least a quarterly basis. The letter also notes that states having secured waivers of the CBR payment under § 1115 waivers must comply with their FQHC/RHC reimbursement terms and conditions, and that FQHCs can raise the issue of whether or not the states’ methodologies under MMMC are adequate for meeting the terms and conditions. Nonetheless, FQHCs face substantial data-based challenges when negotiating these reimbursement rate issues. Even where CBR payments have not been waived, states are aggressively reviewing existing methodologies within the cost-conscious context of their managed care programs and seeking reductions in the CBR payments.

under the Oregon Health Plan still report losses in Medicaid revenues due to substantially lower payment rates.<sup>32</sup>

Finally, and again as illustrated by Table 13, center respondents reported on a variety of challenges posed by managed care participation that had substantial financial implications. The general requirements of new managed care arrangements, ranging from credential procedures to administrative burdens associated with eligibility and plan membership issues to more demanding MIS needs, can only be met by the centers through significant capital outlays and assumption of greater administrative burdens. These challenges essentially associated with the “start-up” of managed care will not be addressed by resolving CBR and rate payments issues.

### ***Implications of Findings for FQHCs***

These findings have substantial implications for the two major questions important to FQHCs operating under Medicaid managed care: how to keep and increase Medicaid patients and how to keep and increase Medicaid revenues.

Although we did not find the direct effect attributable to autoenrollment that we expected, our findings suggest that enrollment policies and practices in general still operate to create substantial indirect effects for FQHCs in terms of whether and how FQHCs will attain and maintain a position in the Medicaid managed care market. Our findings indicate that, in many states, the beneficiary’s ability to choose a provider during enrollment is either 1) foreclosed because this choice is not available or 2) seriously compromised by a lack of information about plans’ provider networks. Consequently, the fact of enrollment process as the gateway to

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<sup>32</sup> Although state officials reportedly have been unconcerned about the struggles of the safety net providers, the recent availability of additional funds for these providers may reflect some rethinking on the part of Oregon legislators and state officials after three years of MMMC.

providers for Medicaid beneficiaries, as well as how the enrollment process is being implemented in many states, illustrate the overarching and long-term implications of enrollment for FQHCs' efforts to adapt to a managed care environment and develop survival strategies for patient recruitment and retention.

The absence of provider information and the lack of informed voluntary choice during enrollment clearly have profound implications for the FQHCs. These providers will not be successful in their strategies to retain existing patients and attract new patients if enrolling Medicaid beneficiaries are not able to choose their PCPs. Whether patients were lost as a result of voluntary selection, the effects of poor enrollment procedures, or the recent decline in Medicaid rolls cannot be ascertained from this study. Evidence in some states that patients were beginning to return to these providers suggests that shifts in voluntary patient care-seeking behavior may be less of a factor in patient losses under mandatory managed care than the effects of poorly-structured enrollment procedures. This **finding** thus points again to the critical importance of improving enrollment procedures.

However, contrary to what we expected, the loss of Medicaid patients as a result of being enrolled in managed care was not a main contributor to FQHCs' worsening financial situation under Medicaid managed care programs. Instead, our findings provide a strong basis for arguing that it is the very financing structure of managed care and not loss of patients that is jeopardizing the survival of the FQHCs and other SNPs. Given the evident struggles of centers in the states that have waived CBR and made no reasonable provisions for transition payments, the FQHCs clearly must establish some alternative forms of financial support, both short-term and long-term given the expiration of CBR as mandated by the BBA.

Our findings do suggest that FQHCs can figure out to

given adequate time and the appropriate support for doing so. Very

efforts to adjust and survive in managed care environment in our study sites

planning to make improvements in data/management information systems,

expense; developing FQHC-based networks or management services organizations

developing FQHC-owned plans; dealing with credential requirements of payers

innovative approaches to staffing and programming; developing new strategies

be a substitute for considering how FQHCs and SNPs will deal with managed care payment rates specifically designed to do away with the cost-shifting that has supported services for the uninsured and thus the mission of the centers.

### ***Recommendations***

In the short-term, however, our findings suggest the following recommendations for FQHCs to address proactively the potential effects of mandatory Medicaid managed care programs; these recommendations are particularly relevant in states where the wholesale shift to Medicaid managed care hasn't occurred. Moreover, it was a common finding across the states that the relative strength of FQHCs and their primary care associations (PCAs) had a substantial effect on their ability to address Medicaid managed care issues and figure out how FQHCs can position themselves in the new systems. Consequently, these recommendations are proposed with the expectation that they can be pursued successfully.

Centers must insist that they be allowed to participate aggressively in enrollment process; it is absolutely critical that enrolling beneficiaries know the names of their providers/FQHCs and how to identify these persons during enrollment. Centers must participate as fully as possible in plans' development of their networks, The development of good relationships with plans will help centers determine how to secure good contract terms and establish supportive referral networks. Centers should work with state officials and the broker (and community-based organizations where relevant) to facilitate involvement with the structure and content of enrollment process. By doing so, centers can ensure that the managed care education of beneficiaries will equip them 1) to make good choices when enrolling , 2) to not be misled about mainstream plans, and 3) to know how to maintain access to FQHCs and unique FQHC services.

Finally, centers must become conversant with patient retention issues and strategies — what do patients want, why do they switch providers, and why do they return.

With respect to financing issues, there are short-term and long-term strategies. FQHCs must be knowledgeable about the BBA provisions that make states directly responsible to FQHCs for CBR. States with § 1915(b) waiver should not be allowed to involve plans in CBR payments and states with new § 1115 waivers should not be allowed to waive CBR. Centers should lobby to remove provisions from contracts between states and plans that would deter plans from contracting with FQHCs or from assigning patients to FQHCs (e.g., special payment for FQHCs). Ensuring that any supplemental payments are made directly from the state to the FQHCs will give the FQHCs their desired “invisible provider protection.” Promoting the establishment of an interim payment system operated by states for safety net providers and other essential community providers may serve to address the financial effects caused by payment delays resulting from plan switching.

Finally, vigorously promoting discussions about the long-term implications of reduced Medicaid rolls and reduced plan payments to providers for the role of safety net providers as the number of uninsured persons continues to grow unabated could serve as a catalyst for improved support.

## **Experiences of Medicaid Beneficiaries Under State Enrollment Practices**

In order to examine the experiences of Medicaid beneficiaries under state enrollment practices for mandatory managed care, we conducted a series of focus groups with beneficiaries in all but one state, Connecticut, for a total of 24 focus groups with 162 participating beneficiaries. We also deliberately structured about one-quarter of these focus groups to consist exclusively of particular types of beneficiaries by conducting focus groups composed exclusively of Hispanic, African American, Asian American, and HIV-infected Medicaid beneficiaries. Although discussed in more detail in the description of the study methods in Appendix B, it is important here to note the caveat about focus groups. Focus groups are not intended to, nor are they designed to, be representative of the experiences of all beneficiaries in a particular state or site. Instead, these focus groups offer a rich picture of how these beneficiaries experienced enrollment under their states' Medicaid managed care programs and suggest insights about beneficiary experiences overall.

In general, the results of the focus groups confirmed informant reports discussed above about the characteristics of the enrollment process including in particular issues related to outreach and education, choice of plan and provider, and ability to use managed care system. Table 14 represents a summary of these results although these highly qualitative and individualized findings are not very amenable to the table format. Regardless of whether they had enrolled voluntarily or had been autoenrolled, most beneficiaries talked about the lack of information about the enrollment process as well as the lack of information about how to use the managed care systems. They frequently reported that, once in managed care, they had more trouble getting care because they did not know which physicians they could see, and they did not know how to make managed care work for them or their families. This general lack of

information and/or lack of accessible and accurate information, was a common theme throughout all of the focus groups.

Although the primary emphasis during enrollment is usually on the ability and opportunity to choose a plan, most beneficiaries were concerned about being able to choose their primary care provider as part of choosing their plan. Unfortunately, beneficiary comments confirmed the discussion above that the most common problem across all of the states was the lack of information about plans' provider networks. Consequently, many beneficiaries talked about their frustrations with not receiving information about which providers were in what plans and about how to stay with their prior provider. In all nine states, beneficiaries frequently recounted their experiences with being unable to continue seeing their regular provider or being assigned to a new provider because they had not been able to choose or when they thought they had in fact chosen.

Beneficiaries talked about their desire to get information from their providers and to be able to seek assistance from their provider during the enrollment process. For many beneficiaries, the relationship with their provider was premised on trust and familiarity, and they wanted to depend upon this relationship for help with managed care procedures. These dynamics seemed to be particularly true for members of the Asian-American and Hispanic focus groups. Many of these participants indicated that they had long-standing provider relationships - these circumstances probably also addressed important issues of cultural and language barriers present during the enrollment process.

The process of enrolling during the conversion to managed care frequently created confusion, anxiety and fear among beneficiaries. These circumstances were usually associated with states that were implementing quickly and failing to make adequate preparation for the

change to managed care. Particularly disconcerting for beneficiaries was the receipt of substantial packets of information in the mail and not being sure about the purpose. These uncertainties about initial enrollment, particularly where was random designation of beneficiaries to be enrolled and substantial lack of information among other stakeholders, sometime created literal stampede of beneficiaries to get enrolled before they lost what they believed would be their only chance to choose a plan and provider. Beneficiaries spoke of uncertainties about deadlines, choice windows, and not really understanding the concept of autoenrollment in relationship to the choice deadlines.

With respect to understanding what enrolling in managed care meant in terms of access to providers and health services, beneficiaries reported a wide range of experiences. The variation often seemed to be associated with several factors including: the beneficiary's education-level, the length of time the beneficiary had been in managed care, how long managed care had been in place in the state, and whether the beneficiary had an existing relationship with a provider and had stayed with this prior provider. Most did not have a clear understanding of the grievance and exemption process and how to access specialty care. While beneficiaries who were autoenrolled often reported experiencing the greatest **difficulty** in terms of finding a provider, accessing care and understanding how to use the system, voluntarily enrolled beneficiaries frequently reported the same problems. These comments highlight the difference between knowing about enrollment process and knowing about how to use managed care.

Perhaps because of their status as Medicaid beneficiaries, many participants expressed reluctance to use the grievance process even when they were aware of it. Participants also showed reluctance to switch plans and providers, even when they were autoenrolled and/or dissatisfied with their current provider and plan. Their comments seemed to suggest that it was

easier and/or preferable “not to rock the boat” and “to leave things alone.” A few beneficiaries commented that the state probably knew better how to make a choice of plan and provider for them.

As noted above, focus groups with HIV-infected beneficiaries were conducted in Oregon, Missouri, and Maryland. In Missouri, these beneficiaries all used a federally-funded center that provided case management services and reported that the center took care of all managed care issues and problems for **them**.<sup>33</sup> In fact, both patients and plans relied on these case management services to ensure appropriate access to services. While Oregon had not established any special procedures for enrolling HIV-infected beneficiaries, the availability of organized local support/advocacy groups (in the urban but not in the rural areas) as well as adequate financing for HIV/AIDS services made a big difference in the transition to managed care. Focus group participants reported that they were able to select the provider and specialists they wanted and that there has been no disruption in care. By contrast, HIV-infected beneficiaries in Maryland reported many problems with enrollment due to lack of knowledge and confusion and indicated that the case managers available to them were not able to address these problems very well. These comments reflect the serious problems with information systems reported by other Maryland informants and the consequences these problems (e.g., inability to link providers with plans, inability to match beneficiaries with providers) during the rapid conversion of entire Medicaid population.

Many beneficiaries expressed belief that their treatment associated with enrolling in managed care was related to their status as Medicaid beneficiaries. They were certain that they

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<sup>33</sup> It is important to understand that SSI-related Medicaid beneficiaries are not required to enroll in MMMC in Missouri under the existing § 19 15(b) waiver or under the soon to be implemented §1115 waiver. These HIV-infected women are all **AFDC/TANF-related** Medicaid beneficiaries enrolled in MC+ whose conditions are not serious enough to qualify them for disability (SSI) benefits.

would have been treated better if they were not Medicaid beneficiaries. Ironically, most of their problems with managed care, such as trying to get specialist information, trying to get services from their prior providers, trying to understand how to use procedures to access emergency room and drug benefits, are exactly the same types of problems experienced by and/or reported by members of commercial plans. Other beneficiaries talked about how “you to had to be very aggressive and be a self-starter” in order to get treated properly and get the appropriate services under Medicaid managed care programs.

There were situations where beneficiaries were very suspicious about the lack of information about the new programs and assumed that the state was deliberately keeping information from them because of their status as Medicaid beneficiaries. A few beneficiaries expressed the belief that the only purpose of the new managed care program was to save money on the backs of Medicaid beneficiaries and there was no intent to improve care or access to care. (Of course some would contend that the same is true in commercial managed care!) This situation was particularly troubling in terms of accessing providers and specialists through plans.

This belief regarding the underlying desire on the part of state officials to conceal network problems surfaced in a particularly troubling way in New Mexico. Advocates for persons with serious mental illness (SMI) asserted that the state withheld important information regarding networks in order to hide the fact that the plans’ networks were inadequate to furnish mental health services. Advocates believed that plans had been permitted to begin accepting enrollees despite state officials being aware that their networks were incomplete and inadequate. Although focus group participants in NM did not include SMI individuals, advocates and CBO representatives described how SMI beneficiaries were unable to enroll in plans that included

their existing providers and thus were also unable to access either their current provider or needed specialists, and experienced serious delays and barriers to badly-needed care.

State officials frequently assumed that Medicaid beneficiaries had no interest and/or little capacity to learn about managed care. These attitudes may have also contributed in some states to less aggressive efforts at outreach and education about managed care. However, most beneficiaries evidenced strong interest in understanding managed care along with a clear realization that this new program would fundamentally affect how they would access care. In fact, beneficiaries wanted to know the same things about managed care as we hear that commercial managed care enrollees ask about. For example, how do I access specialists, how do I get my prescriptions filled, how do I make sure that I can take my children to their regular pediatrician.

There were no evident or overarching patterns of differences and/or similarities among beneficiaries in terms of their experiences with managed care and the approach of particular states to implementing their managed care programs. There were few issues apparently related to culture. For example, Asian and Hispanic beneficiaries reported having more trouble understanding about switching and then actually being willing to switch. These beneficiaries, when they didn't have a regular provider like the other beneficiaries, also frequently reported that, again like the other beneficiaries, they would not try to change plans or providers and would just stay put with the state's choice which they assumed was a good one.

One interesting dynamic in the focus groups involved the number of participants who said they were satisfied with the services under mandatory Medicaid managed care notwithstanding that they had just reported about a number of problems and frustrations with the program. The beneficiaries reporting greater satisfaction tended to be beneficiaries who had kept

their prior providers and/or who had long-standing relationship with their providers. However, these findings may also suggest that satisfaction is not a very informative outcome measure when assessing how well enrollment policies and procedures “work.”

Beneficiaries demonstrated a range of reactions to and experiences with managed care that were very similar to what has been commonly reported by plan members in commercial settings. They are definitely interested in and capable of learning about the fundamentals of managed care • they understand that they need to know about more than just how to get enrolled. Numerous informants commented on and agreed about the need for ongoing education about managed care beyond the enrollment process. Certain types of beneficiaries (e.g., those who first language is not English) may be more susceptible to waiving opportunities to choose and/or to being unwilling to assert rights or get engaged in the managed care system without an appropriate intermediary, such as their provider or a CBO representative. The experiences of the HIV-infected beneficiaries demonstrate the value of face-to-face counseling and assistance for enrolling in and for navigating managed care; these finding suggest that all beneficiaries, as well as plans and providers, would benefit from these services.

## Conclusions and Recommendations

The findings from this study underscore the challenges that surround the conversion to mandatory managed care. Enrollment is basic to any insurance system and is of particular significance where enrollment is mandatory and the purchaser that oversees enrollment is attempting to transition to a system where market power is essential to success. The issue of enrollment brings into sharp focus two countervailing priorities: (a) the need to ensure that individuals understand and accept managed care as well as preserve the integrity of the underlying provider/patient relationship on which the health system is built; and (b) the need to move thousands of people into managed care swiftly and in sufficiently high volume to achieve market power. We first summarize the implications of our findings and then present recommendations.

### The Significance of Enrollment's Dual Role

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As we examined the findings about enrollment policies and practices across the nine states and ten sites, it became evident that the enrollment process plays two pivotal roles: 1) ensuring that covered individuals actually enter a plan, a crucial step in a system in which coverage and payment for services is conditioned on membership in a plan, and 2) giving states the necessary leverage to create a market among managed care plans through the availability of large blocs of covered lives.

It was also evident that these two roles are potentially in **conflict**. This is because many of the desirable characteristics of an enrollment process designed to achieve high rate of voluntary enrollment, (e.g., lengthy choice windows, extensive information about plans and

provider networks, and intensive, face-to-face choice counseling) could impede rapid establishment of a stable market through the guaranteed enrollment of large bloc of covered lives, with few administrative burdens on participating plans to deal with new members' plan and provider preferences.

The site studies illustrate the tensions that arise among the stakeholders as this **difficult** process moves along. State **officials**, while were strong in their concern over beneficiary welfare and the need to preserve the fundamental strength of the health care system, felt the pressures that flow from the need to alter their programs rapidly and overcome the complications created by the obligation to enroll thousands — and in some cases hundreds of thousands — of persons into managed care arrangements. Beneficiaries were frustrated by the lack of information and this frustration was evident even among those who understood enough to select a plan voluntarily. Community providers expressed deep concerns over the problems with the provider network information that was furnished as well as the effects of the process on their ability to remain viable.

The market pressures on state agencies to maintain their bargaining leverage in creating a market by purchasing care in large, stable blocs were also evident from the findings. State officials, concerned about both the plans' need for a certain number of covered lives within a certain period of time and their own promises of cost savings through managed care, pursued a strategy of rapid, large-scale implementation — sometimes before contracts with plans were even finalized and provider networks in place — with inadequate provisions for enrollment education. High rates of autoenrollment represented an acceptable price, and frequently a valuable bargaining tool, for such responses to market pressures.

## Beneficiaries, Plans, and Providers

Plans were uniformly troubled about two enrollment issues: 1) challenges presented by the unstable enrollment patterns of their Medicaid members, and 2) fewer than expected covered lives caused by falling Medicaid rolls. Escalating monetary losses and increased competition for Medicaid lives have heightened plans' enrollment concerns, particularly regarding the consequences for stable plan membership of states' liberal plan switch policies to compensate for poor enrollment procedures. As the Medicaid market continues to shrink in terms of covered lives, and as plans grapple with unanticipated challenges, states will likely face increased pressure to modify certain aspects of their enrollment procedures to encourage plan participation.

FQHCs were deeply affected by states' approaches to enrollment. Numerous **enrollment-**related concerns were commonly identified across the sites. In particular, the absence of provider information and the lack of informed voluntary choice during enrollment clearly have profound implications for the FQHCs. These providers will not be successful in their strategies to retain existing patients and attract new patients if enrolling Medicaid beneficiaries are not able to choose their PCPs. Moreover, evidence in some states that patients were beginning to return to these providers suggests that shifts in voluntary patient care-seeking behavior may be less of a factor in patient losses under mandatory managed care than the effects of poorly-structured enrollment procedures. This finding thus points again to the critical importance of improving enrollment procedures.

Most beneficiaries stressed their confusion and frustration over the lack of information about providers and plans and their inability to figure out how to stay with their provider. Beneficiary responses frequently indicated a basic lack of understanding about access implications of managed care enrollment despite their voluntary enrollment status. However,

while we found evidence that it is possible to improve beneficiary understanding of managed care and how to make the system work for them, confirming the findings of other studies of beneficiary education initiatives, it is likely that systematic improvements in the enrollment process will depend more on the current status of market pressures and less on the desire to inform and educate beneficiaries.

### **Critical Lack of Accurate Information During Enrollment**

The absence of accurate information prior to and during enrollment about provider networks, and the implications of that absence, constitutes the single most important finding in this study. To the extent that this information is not available to beneficiaries, the most important consequences of enrolling in managed care — effects on access to their providers and/or regular sources of care — are lost to the population being enrolled. The findings from this study suggest that the **difficulties** associated with implementing mandatory systems made the provision of timely and accurate provider information difficult and usually impossible.

Perhaps the most compelling findings concerned beneficiaries' ability to choose their primary care provider (PCP) during enrollment. We found that enrollees were uniformly more concerned about choosing their PCP than their plan and that the most common reason for plan switching was the inability to **find** one's provider in the plan. Unfortunately, in all the states to varying degrees, beneficiaries experiences great **difficulties** in choosing their providers. The lack of a successful means for dealing with the issue of provider/patient relationships has been the catalyst for many of the other enrollment-related issues identified during the course of the study and has profound implications for safety net providers as well as beneficiaries.

## Need for Constructive and Collaborative Dialogue

Finally, two striking aspects of the site visits were the level of tension and concern expressed by many informants and evidence of substantial mistrust between state officials and FQHC representatives. At the same time, equally compelling were the numbers of state officials, advocates, health center representatives, and plan officials trying to struggle in a creative way to address difficult issues. Notwithstanding predictable self-interested actions by all parties, we found no evidence that state officials or plan representatives were deliberately intending to harm health centers or mislead beneficiaries. State officials are, for the most part, trying to do the right thing albeit frequently with limited resources and a narrow focus. It is probably fair to say that the transformation would be somewhat easier if the trust levels among the parties were strong enough to support collaborative problem solving.

We conclude that the universal challenge for all states establishing mandatory Medicaid managed care programs is the struggle to balance the competing demands of these two enrollment functions. States may not realistically be able to avoid market imperatives no matter how well intentioned about achieving high rates of voluntary enrollment. Moreover, the well-recognized challenges of administering mandatory enrollment systems for Medicaid beneficiaries are exacerbated by the consequences of these enrollment tensions; these dynamics will further mitigate against well-structured voluntary enrollment systems. However, as our findings do suggest strategies to improve enrollment and its outcomes, we make the following recommendations.

## **Improving Enrollment**

Despite the complex and conflicting demands associated with enrollment, and notwithstanding the reality that shorter-than-desirable enrollment periods will probably take precedence over a more gradual transformation through enrollment, there are manageable ways to improve enrollment. These strategies include: 1) enhancing efforts at advance preparation for mandatory enrollment periods with comprehensive information and education available to all stakeholders; 2) imposing more responsibilities on, as well as providing more resources to, brokers to make enrollment more accessible; 3) ensuring that comprehensive provider information is available before mandatory enrollment begins; 4) ensuring that thorough explanations of provider networks are developed and available including how to access certain traditional providers and specialty care; 5) increasing the incidence and quality of **community-**based education efforts that include a focus on implications of managed care enrollment on access to regular source of care; 6) allowing a greater role for providers in educating patients about managed care that balances provider abuse concerns with patient needs; and 7) continuing to increase the role of, as well as resources allocated to and oversight of, community-based organizations involved in the enrollment and education process.

Our findings strongly suggest that simply achieving high rates of voluntary enrollment is not a sufficient measure of the adequacy of the enrollment process and whether beneficiaries have gained about knowledge about managed care beyond enrollment. Ongoing and accessible education about managed care, that involves all stakeholders, is necessary.

## **Achieving Market Power**

There is no doubt that in a competitive system in which the product that is bought and sold is as complex as managed care, states need market power. Given the short duration of enrollment in Medicaid, states have tended to rely effectively on rapid enrollment of beneficiaries for short periods of time as a means of gaining leverage in the market place. This approach produces downsides, since it permits market manipulation by some companies who could conceivably delay care in order to maximize profits over the short run, a threat that is heightened by state efforts to gain additional short term gains by rewarding the most lives to the lowest bidder, demanding further discounts for autoenrolled lives, and establishing “safeguards” (such as disenrolling autoenrolled persons who are not served in the first several months) that may in fact depress utilization further. In other words, states appear to be attempting to rely on the fact of short-term enrollment to gain the upper hand in the market, when in reality greater buying power might be achieved by taking an opposite tack.

In our opinion the best means for gaining a market advantage would be to switch enrollment to a system in which individuals are enrolled for long periods of time once a plan selection is made, so that the dollar value of their enrollment increases. This approach also would make outcomes and performance measurement more feasible, since more measurable results might be expected in a system in which a member is a member for a decent period of time. Our findings also suggest that most plans would welcome this approach to structuring as plan representatives were most and uniformly troubled about the instability of their plan membership and costs associated with this phenomenon.

The 12-month enrollment option for children under 19 in our opinion offers a means of creating a more advantageous market situation. While this option is not available for adults, it

could be considered as part of a § 1115 demonstration. At a minimum, the BBA options of 6 months guaranteed enrollment, as well as reenrollment in the same plan following short term breaks in eligibility are important.

Another issue in the area of market power, and potentially of even greater importance, is the overall decline in Medicaid enrollment that may potentially be accompanied by increases in delayed enrollment at a time of illness. Studies by CHPR and others have pointed to structural problems in Medicaid enrollment as welfare offices are effectively dismantled or reformed. For market reasons it is in the interest of Medicaid agencies to address this basic change in the process of enrolling in Medicaid, through redesign of the application process and better integration of the Medicaid enrollment process with the job search and work system that is evolving in states. Such efforts could ensure that Medicaid-eligible adults and children do not continue to “fall through the cracks” and that the healthier potential eligibles aren’t lost to enrollment until they are sick. Again, as noted above, plans would welcome and support such approaches to developing the market as they would benefit from enrollees/new members who will not be immediate high users of care.

### **Providing Accurate and Timely Information**

Solving the problem of inaccurate information and the lack of information is critical to the basic integrity of managed care. Even more than the privately insured, Medicaid beneficiaries must know who is in their networks when they select a plan. Otherwise, care will be compromised, and inappropriate care seeking patterns may not change. In addition, the inability of beneficiaries to select plans based on information about provider networks will disproportionately affect the safety net providers as beneficiaries will no doubt select plans

without their traditional provider and/or inadvertently “waive” their entitlement to FQHC services. Findings from the beneficiary focus groups as well as informant interviews suggest that it is frequently difficult for beneficiaries to switch plans and providers notwithstanding liberal post-enrollment switch policies.

An important question is whether the technology exists for plans to develop “real-time” provider network membership systems that can convey precise information and maintain the information in a sufficiently up-to-date fashion to allow for effective and timely informing. Waiting until after the member has enrolled poses disclosure problems, because plans are under great pressure at this point to connect members with providers and cannot spend as much time as might be warranted on selection assistance. The appropriate management information system (MIS) could provide electronic access to current provider information and render the need for “hard copy” provider directories, which have proven to be difficult for beneficiaries to use and cumbersome for states, obsolete. This approach would, however, require changes in enrollment procedures. For example, to ensure beneficiary access to electronic provider information, enrollment would have to be done by telephone or in person and not by mail.

To the extent that such MIS capabilities exist, states should consider making their use a requirement of contracting; indeed, states could develop such software systems for their own use. If these capabilities do not exist, a high priority probably should be placed on their development. As interim measures, states could 1) allow much greater provider involvement in the enrollment process, particularly with respect to advising patients/beneficiaries about their plan affiliations, and 2) consider allowing plan disenrollment for cause in the case of all individuals who find themselves enrolled in plans by mistake due to erroneous provider network information. State

officials will have to consider how to address the plans' concerns about the membership instability associated with such policies.

### **Educating Beneficiaries About Managed Care**

The findings in this study suggest that the enrollment process does not equate with a basic information program for managed care beneficiaries. Only steady and ongoing support for community-responsive information and education programs will, in our view, improve beneficiary understanding about the managed care process over the long run. These community efforts should be encouraged and funded as part of the overall administrative budget for state Medicaid managed care programs. The role of the broker and community-based organizations is particularly key in these efforts. State officials must also set clear guidelines for oversight and outcome monitoring as the focus groups findings indicate that beneficiary satisfaction is not necessarily a good measure of whether or not the enrollment process successfully equipped beneficiaries to navigate the new system and access care.

### **Supporting the Safety Net During the Transition Period and Beyond**

It is evident that a confluence of events – declining Medicaid rolls, managed care enrollment difficulties, deeply discounted payment rates and the problems created by the loss of cost-based reimbursement with inadequate supplemental payment system; have resulted in patient losses and revenue losses for many health centers and other safety net providers. As these **difficulties** mount, the belief that there is a deliberate effort to curb the existence of these providers grows. This is a highly unfortunate situation that contributes to the inability to find solutions acceptable and beneficial to all stakeholders. As noted above, while there is little doubt

about the adverse effects on FQHCs, we found no evidence for a deliberate intent to develop and implement policies harmful to health centers.

We proposed extensive recommendations for FQHCs above and do not repeat them here. However, suffice to say that addressing the lack of provider information during enrollment must be a priority. Provider information should be conveyed in a manner that does not disadvantage clinical providers who have excellent PCP staff but who are known to their communities by their clinical names. FQHCs must be involved in providing this information to their patients. This approach will go a long way toward addressing patient losses.

But, our findings also reveal serious **financial** losses for the health centers, both current and future, and a need to develop a more workable solution to the problem of supporting care for the uninsured. Medicaid agencies and managed care plans see the FQHC reimbursement system as a legally-required, cross-subsidization scheme and are increasingly unconcerned about whether their payments may in fact fall well short of the mark of permitting these safety net providers a fair cost recovery. In this regard, there may be a need for a several-pronged approach. One issue is the development of risk assessment measurement methods that permit more accurate payment for Medicaid beneficiaries in accordance with health profiles. Some states have begun this effort, and it should be encouraged. Of particular importance is making sure that any risk adjustment ensures payment to the provider that actually treats higher risk patients and does not simply result in higher payments to plans.

A separate issue is devising an enhanced mechanism for supporting activities related to the care of uninsured patients. The FQHC payment amendments contained in the BBA were temporary only and are proving to be highly contentious. We believe that it would be advisable to convene a working group to attempt to devise realistic solutions to this problem, so that the

choice for health centers does not have to be between caring for Medicaid beneficiaries and remaining true to the mission of caring for the uninsured.

### **Engaging in Constructive Dialogue and Strategic Problem Solving Based on Common Interests of Stakeholders**

Just as the tensions around provider payment and information were palpable, so were matters relating to the community orientation and cultural sensitivity of managed care systems. Whether the issue is the appropriateness of information for Indian residents, the lack of support for persons with mental disabilities, or community perceptions that important information is being withheld to mislead beneficiaries, the current climate of tension, mistrust, and anger is unfortunate. We believe that public and private policymakers should seek ways to generate collaborative and public-spirited dialogue through meetings, conferences, and small group sessions where the various stakeholders can achieve a greater understanding of the challenges inherent in this transformation, gain a greater appreciation for each others' difficulties and challenges, and examine/assess the types of supports that would ease the way. "

Common interests are present among the states, the managed care plans, and the FQHCs; these commonalities should be exploited to improve enrollment process. Common interests are present among the states, the managed care plans, and the FQHCs; these commonalities should be exploited to improve enrollment process. Enrollment-related strategies based on enlightened self-interest of all stakeholders could include:

- ❖ State officials can decide to establish longer periods of guaranteed Medicaid eligibility for all beneficiaries (e.g., at least 12 months). This would provide plans with more stable membership and increase the likelihood that beneficiaries will learn how to use managed care.

- ❖ State officials can improve its outreach efforts designed to identify and enroll potential eligibles and to reduce the welfare reform-related dynamics of eligibles “falling through the cracks.” The effects of fluctuating eligibility can be mitigated by providing for reenrollment in same plan after short periods of ineligibility. This will benefits plans as well as enrolling more eligibles in Medicaid.
- ❖ State officials can commit to working with CBOs and providers to ensure that beneficiaries have a meaningful opportunity to choose their primary care provider during enrollment process. This will reduce plan switching, benefit traditional providers, and increase beneficiary satisfaction.
- ❖ State officials can commit to establishing comprehensive education programs that are community- and/or provider-based and that will better equip beneficiaries to use the managed care system. This will reduce plan switching, encourage appropriate service use, and increase beneficiary satisfaction.
- ❖ State officials can commit to enhanced efforts to improve the process of matching autoenrolled persons, as well as voluntarily enrolled persons who did not choose a PCP, with their prior providers. This will reduce plan switching, encourage appropriate service use, and increase beneficiary satisfaction.
- ❖ Although this recommendation is broader than a purely enrollment-related strategy, state officials could consider using their Section 193 1 options to expand eligibility for Medicaid. This approach could offset declines in Medicaid rolls and provide more covered lives to managed care plans.

Collaborative dialogue will yield solutions that can address all stakeholder needs in a forward-looking manner with a special emphasis on the FQHCs/SNPs and the uninsured. Mandatory Medicaid managed care programs may be inherently incapable of dealing successfully with the types of enrollment-related problems that 1) involve balancing the tensions between the two functions of enrollment, and 2) have the potential to affect disproportionately the safety net infrastructure. Consequently, all concerned parties must put aside apparent differences and endeavor to let enlightened self-interest guide efforts to improve enrollment.

**TABLES 1 - 14**

TABLE 1 STATE CHARACTERISTICS

	Los Angeles County	California Santa Clara County	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon	U.S. Average
<b>Total Population</b>	9,470,900	32,268,30	3,269,858	14,653,945	5,094,289	9,773,892	5,402,058	1,729,751	3,317,091	3,243,487	267,636,061
<b>Racial/Ethnic Distribution</b>											
White		80.0%	88.4%	82.9%	68.9%	83.6%	87.4%	87.0%	83.2%	93.8%	82.8%
Black		7.4%	9.1%	15.1%	27.1%	14.3%	11.2%	2.5%	7.7%	1.8%	12.6%
Hispanic		30.2%	7.7%	14.0%	3.4%	2.5%	1.4%	39.5%	3.5%	5.5%	10.7%
Asians		11.6%	2.2%	1.7%	3.7%	1.5%	1.0%	1.3%	1.3%	3.0%	3.7%
Native American		1.0%	0.2%	0.4%	0.3%	0.6%	0.4%	9.2%	7.9%	1.4%	0.9%
<b>Poverty Rate</b>		17.2%	10.7%	15.1%	10.4%	12.5%	11.5%	24.0%	16.8%	11.6%	14.0%
Children		27.2%	19.7%	27.2%	19.8%	21.3%	20.3%	36.6%	24.2%	19.6%	22.9%
Adults		13.8%	7.0%	13.4%	8.4%	10.7%	11.7%	19.9%	14.0%	10.5%	11.8%
Elderly		10.0%	7.0%	17.2%	17.4%	12.4%	11.3%	21.3%	17.1%	10.5%	15.7%
<b>Poverty Rate</b>											
Black		25.7%	35.3%	34.5%	20.1%	36.9%	38.1%	no data	36.5%	no data	31.8%
Hispanic		27.6%	39.0%	24.9%	16.7%	27.6%	no data	27.2%	43.0%	23.9%	29.0%
<b>Insurance Coverage</b>											
Medicaid		18.1%	7.9%	13.2%	9.3%	11.5%	10.7%	16.0%	11.9%	10.4%	12.2%
Uninsured		19.7%	10.4%	19.2%	14.4%	10.4%	13.4%	25.6%	19.3%	13.7%	15.5%
<b>Uninsured</b>											
< 100% FPL		23.0%	18.7%	23.7%	21.8%	15.2%	24.9%	33.6%	25.2%	16.3%	22.9%
100-200% FPL		31.0%	26.4%	32.4%	27.4%	21.4%	21.1%	41.6%	32.5%	23.2%	27.4%
<b>Health Indicators</b>											
Infant Mortality Rate		6.0	6.2	7.5	8.4	7.9	8.1	5.9	8.9	5.6	7.2
Low Birth Weight Immunization Rate		6.0%	7.2%	7.9%	8.5%	7.6%	7.5%	7.5%	7.4%	5.3%	7.4%
		75.0%	88.0%	77.0%	78.0%	73.0%	74.0%	75.0%	69.0%	72.0%	76.0%
<b>Economic Indicators</b>											
Per Capita Income		\$25,346	\$33,875	\$24,226	\$27,618	\$24,945	\$23,022	\$18,803	\$19,544	\$23,074	\$24,426
Unemployment Rate		6.3%	5.1%	4.8%	5.1%	4.2%	4.2%	6.2%	4.1%	5.8%	4.9%
% Budget Spent on Health		11.2%	11.5%	15.0%	12.2%	12.5%	13.4%	11.3%	12.6%	11.6%	12.1%

## EXPLANATION OF COLUMN HEADINGS AND DATA SOURCES

### **Total Population 1996**

**Source** : O'Leary Morgan K., Morgan S., eds. State Rankings 1998: A Statistical View of the 50 United States. Morgan Quitno Press, 9<sup>th</sup> edition, 1998.

### **Total Population for Los Angeles and Santa Clara 1996**

Source: State of California, Department of Finance, Race/Ethnic Population Estimates: Components of Change by Race 1990-1996, Sacramento, California, January 1998, <http://www.dof.ca.gov/html/Demograp/e1table.htm>.

### **Racial Ethnic Distribution 1996**

**Source**: O'Leary Morgan K., Morgan S. , eds. State Rankings 1998: A Statistical View of the 50 United States. Morgan Quitno Press, 9<sup>th</sup> edition, 1998.

### **Poverty Rate: 1996.**

**Source**: O'Leary Morgan K., Morgan S., eds. State Rankings 1998: A Statistical View of the 50 United States. Morgan Quitno Press, 9<sup>th</sup> edition, 1998.

### **Poverty Rate: Children/Adults/Elderly 1994-95**

**Source**: Long, P., Liska D., eds. State Facts: Health Needs and Medicaid Financing, Kaiser Commission on Medicaid, February 1998.

### **Poverty Rate: Black/Hispanic**

**Source**: Three-year average of U.S. Census Bureau Current Population Survey (1993-1995), <http://www.newfederalism.urbsn.org>.

### **Insurance Coverage/ Uninsured Minority 1994-1995**

**Source**: Long P., Liska ,P., eds. State Facts: Health Needs and Medicaid Financing, Kaiser Commission on Medicaid, February 1998.

### **Health Indicators**

**Source**: O'Leary Morgan K., Morgan S., eds. State Rankings 1998: A Statistical View of the 50 United States. Morgan Quitno Press, 9<sup>th</sup> edition, 1998.

### **Economic Indicators**

**Source**: O'Leary Morgan K., Morgan S., eds. State Rankings 1998: A Statistical View of the 50 United States. Morgan Quitno Press, 9<sup>th</sup> edition, 1998.

TABLE 2 CHARACTERISTICS OF STATE MEDICAID PROGRAM

	California Los Angeles County	Santa Clara County	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon	U.S. Average
<b>Eligibility</b>											
Pregnant Women and Infants < 1	200%		185%	185%	185%	185%	185%	185%	150%	133%	133%
Children 1-5	133%		185%	133%	185%	150%	133%	185%	133%	133%	100%
Children 6-19	100%		185%	100%	185%	150%	100%	185%	100%	100%	100%
<b>Coverage</b>											
Children	32.3%		15.9%	27.3%	19.4%	19.8%	24.1%	31.1%	23.3%	15.8%	23.1%
Adults	10.9%		4.4%	6.8%	4.9%	7.4%	5.2%	7.0%	6.7%	7.9%	7.1%
<b>Coverage</b>											
< 100% FPL	61.7%		54.6%	54.9%	50.1%	61.2%	49.1%	50.0%	52.4%	52.6%	54.9%
100-200% FPL	27.7%		12.6%	14.0%	15.3%	13.4%	17.6%	11.2%	11.2%	10.5%	16.5%
<b>Enrollment</b>											
Total (in thousands)	4,942		366	1,734	413	1,164	695	283	393	452	
Children	2,322		178	1,038	207	549	348	170	200	159	
Adults	1,392		86	209	73	306	157	58	86	209	
Blind & Disabled	742		49	276	86	223	98	37	56	46	
Elderly	486		53	211	47	86	93	17	51	38	
<b>Spending (per beneficiary)</b>											
Children	\$1,206		\$1,415	\$1,570	\$2,635	\$1,790	\$986	\$1,086	\$1,232	\$1,644	\$1,451
Adults	\$1,725		\$2,062	\$2,419	\$3,280	\$2,036	\$1,162	\$1,794	\$1,300	\$1,717	\$2,080
Blind & Disabled	\$6,572		\$18,502	\$6,920	\$11,026	\$8,701	\$7,169	\$8,488	\$7,138	\$10,154	\$8,784
Elderly	\$6,569		\$19,965	\$8,313	\$12,330	\$13,141	\$8,715	\$7,743	\$6,889	\$8,484	\$10,308
<b>% Births Financed</b>	42.0%		25.0%	45.0%	32.0%	33.0%	42.0%	53.0%	42.0%	35.0%	39.0%
<b>Growth</b>											
Beneficiaries	6.4%		8.5%	11.9%	4.7%	2.3%	9.2%	16.9%	7.7%	14.7%	7.9%
Spending (w/DSH)	15.1%		18.0%	19.3%	15.8%	14.3%	23.9%	20.8%	9.3%	21.8%	16.7%
Spending (w/out DSH)	4.0%		5.1%	5.8%	9.2%	10.2%	7.7%	2.8%	1.3%	5.9%	5.7%
<b>% Budget Spent on Medicaid</b>	19.2%		16.2%	15.8%	17.9%	19.7%	21.7%	13.4%	14.3%	14.4%	20.4%

## EXPLANATION OF COLUMN HEADINGS AND DATA SOURCE FOR ENTRIES

### Eligibility (1997)

**Source:** Long P., Liska D, eds. State Facts - Health Needs and Medicaid Financing, Table 16, p. 131, Kaiser Commission on Medicaid and the Uninsured.

### Coverage & Coverage FPL (1994-95)

**Source:** Long P., Liska,D.,eds. State Facts - Health Needs and Medicaid Financing. Kaiser Commission on Medicaid and the Uninsured.

### Enrollment (1995)

**Source:** Long P., Liska, D.,eds. State Facts - Health Needs and Medicaid Financing. Kaiser Commission on Medicaid and the Uninsured.

### Spending, % Births financed, & Growth (1995)

**Source:** Long P., Liska D., eds. State Facts - Health Needs and Medicaid Financing. Kaiser Commission on Medicaid and the Uninsured.

### % Budget Spent on Medicaid (1995)

**Source:** Long P., Liska D., eds. State Facts - Health Needs and Medicaid Financing. Kaiser Commission on Medicaid and the Uninsured.

### Year Began Managed Care

**Source:** Horvath J. and Kaye N., eds. Medicaid Managed Care A Guide for States. National Academy for State Health Policy, 3<sup>rd</sup> edition, 1997.

TABLE 3 MANDATORY MEDICAID MANAGED CARE PROGRAM CHARACTERISTICS

	California	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon	
	Los Angeles County	Santa Clara County								
<b>Initiative Type/Name</b>	Two-Plan Model	Two-Plan Model	Connecticut Access	MediPass and HMO	HealthChoice	Comprehensive Health Plan Program	MC+	Salud!	SoonerCare	Oregon Health Plan
<b>Program Type</b>	Full Risk	Full Risk	Full Risk	Full Risk and PCCM	Full Risk	Full Risk	Full Risk	Full Risk	Full Risk and PCCM	Full Risk
<b>Waiver Type</b>	1915(b)	1915(b)	1915(b)	1915(b)	19159(b)/1115	1915(b)	1915(b)/1115	1915(b)	1915(b)/1115	1115
<b>Year Began</b>	1996	1996	1995	1991	1991/1996	1997	1995/1998	1997	1995/1996	1994
<b>Geographic Coverage</b>	County	County	Statewide	Statewide	Statewide	5 counties and expanding statewide	4 Regions (planning to expand to 5 <sup>th</sup> )	Statewide	SoonerCare Plus in urban areas	Statewide
<b>Commercial MC Penetration Rate<sup>2</sup></b>	40%		30%	23%	31%	22%	24%	15%	10%	45%
<b>Medicaid MC Penetration Rate<sup>3</sup></b>	38%	42%	60%	78%	80%	38%	42%	75%	50%	90%
<b>Populations Required to Enroll</b>	AFDC/TANF	AFDC/TANF	AFDC/TANF	AFDC/TANF SSI	AFDC/TANF SSI	AFDC/TANF SSI	AFDC/TANF	AFDC/TANF SSI	AFDC/TANF <sup>4</sup>	AFDC/TANF SSI
<b>Total MMMC Enrollment Spring 1998</b>	1.8 million	63,000	220,000	1.1 million	330,000	460,000	248,000	201,000	144,300	337,800
<b>Plan Licensing Requirements</b>	State-licensed HMOs	State-licensed HMOs	Lower solvency required for provider-sponsored plans	State-licensed HMOs	Lower solvency requirements for provider-sponsored plans	Meet state QHP requirements to apply for state license w/in 1 year	State-licensed HMOs	State-licensed HMOs	State-licensed HMOs	Provider-sponsored plans exempt from HMO licensure
<b>Participating Plans</b>	2	2	7	15	9	18	12	3	5	15
<b>Commercial Provider-Sponsored</b>	1	1	5	13	3	17	9	3	3	14
<b>Publicly-Sponsored</b>			2	(1 <sup>5</sup> )	6	1	2			1
	1	1		2			1		2	

<sup>1</sup> In December 1995, Florida received a renewal of its §1915(b) waiver, and in 1996, Florida amended its waiver to allow the state to award autoenrolled lives to either HMOs/PHPs or MediPass.

<sup>2</sup> Source: The InterStudy Competitive Edge 6.2, Part II: HMO Industry Report, September 1996. Please note that only the penetration rate for the state of California was available.

<sup>3</sup> Time period for determining the Medicaid MC penetration rate varied by state but was usually between six to twelve months and between early Fall 1997 and late Spring 1998.

<sup>4</sup> SMI/SED populations are required to enroll as of July 1998.

<sup>5</sup> A FQHC-sponsored plan has been established but was not yet operational at the time of our case study.

**TABLE 4 ENROLLMENT POLICIES FOR MANDATOR , MEDICAID MANAGED CARE PROGRAMS**

	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
<b>Populations Required to Enroll</b>	AFDC/TANF	AFDUTANF	AFDUTANF	AFDC/TANF SSI	AFDC/TANF SSI	AFDC/TANF SSI	AFDUTANF	AFDUTANF SSI	AFDUTANF <sup>1</sup>	AFDC/TANF SSI
<b>Length of Choice Window</b>	30 days	30 days	30 days	30 days	21 days	30 days	30 days	16 days	14 days	45 days
<b>Method of Enrollment</b>	In person and by mail	In person and by mail	In person, by telephone, and by mail	In person, by telephone, and by mail <sup>2</sup>	In person, by telephone, and by mail	In person, by telephone, and by mail	By telephone and by mail	By telephone and by mail	In person, by telephone, and by mail <sup>3</sup>	In person and by mail <sup>4</sup>
<b>Who Enrolls Beneficiaries</b>	Broker	Broker	Broker	Plans <sup>5</sup>	Broker	Broker	Broker	Fiscal Agent	State/DHS and State broker	State broker
<b>Voluntary Enrollment Rate<sup>6</sup></b>	68%	71%	90%	26%	60%	50%	80%	48% (Regions I-III)	40%	100%
<b>Plan Lock-in</b>	No	No	No	No	Yes	Yes <sup>7</sup>	No	Yes <sup>8</sup>	Yes	Yes
<b>Plan/Provider/ CBO Involved in Enrollment</b>	Plan - no Provider - yes (initially) CBO - yes	Plan - no Provider - yes (initially) CBO - no	Plan - no Provider - yes (can call from provider's office) CBO - yes	Plan - yes Provider - yes (during full conversion to MediPass only) CBO - no	Plan - no Provider - no CBO - yes	Plan - no Provider -yes (can call from provider's office) CBO - yes	Plan - no Provider -no CBO - no	Plan - no Provider - no CBO - yes	Plan - no Provider - no CBO - no	Plan - no Provider - yes (outstationed eligibility workers) CBO - no
<b>PCP Selection at Enrollment</b>	Strongly encouraged	Encouraged	Not Available	Available*	Strongly encouraged	Encouraged	Encouraged	Encouraged	Available	Not Available
<b>Health Status Collected</b>	No, other than pregnancy status	No, other than pregnancy status	No	No, other than pregnancy status	Yes <sup>9</sup>	No	Yes	No	No	No, other than pregnancy status
<b>Plan Switch Policy</b>	Monthly without cause	Monthly without cause	Monthly without cause	Anytime without cause	Within initial 30 days without cause	Anytime without cause <sup>10</sup>	Anytime without cause	Anytime without cause <sup>11</sup>	Within initial 30 days without cause	Switch only with cause

<sup>1</sup> SMI/SED populations are required to enroll as of July 1998.

<sup>2</sup> In person with pre-enrollment by plans (at beneficiary's request); mailed assignment to MediPass provider (must call to change).

<sup>3</sup> Beneficiaries may enroll in person at DHS offices and by telephone or by mail with the enrollment broker.

<sup>4</sup> In person at select provider sites (FQHCs and DSH hospitals) and at welfare offices (cash assistance applicants), and by mail.

<sup>5</sup> At the time of our site visit, plans were directly involved in enrolling beneficiaries. This is expected to cease with assumption of enrollment responsibilities by broker.

<sup>6</sup> This rate represents the current voluntary rate.

<sup>7</sup> Lock-in w/federally-qualified HMO plans.

<sup>8</sup> Chosen at time of pre-enrollment to plan (plan marketers assist beneficiaries) or with assignment to MediPass provider.

<sup>9</sup> Plans must contact and set up a PCP appointment for high-risk beneficiaries within 10 days.

<sup>10</sup> Without cause within 30 days if federally-qualified HMO.

TABLE 5 EDUCATION AND OUTREACH ABOUT ENROLLMENT

	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara county								
<b>Extent of Efforts at Education and Outreach</b>	Extensive; Broker has primary responsibility	Moderate; Broker shares responsibilities with state	Substantial; Broker shares responsibilities with state but does more	Minimal; No broker involvement <sup>1</sup>	Moderate; Broker shares responsibilities with state	Moderate; Broker shares responsibilities with state but does more	Extensive; Broker has primary responsibility	Substantial; State has primary responsibility	Minimal; State has primary responsibility	Moderate; No broker involvement
<b>Voluntary Enrollment Rate (Current)</b>	68%	71%	90%	26%	60%	50%	80%	48%	40%	100%
<b>Who Enrolls Beneficiaries</b>	Broker	Broker	Broker	Plans (HMOs)	Broker	Broker	Broker	Fiscal Agent	State/DHS and Broker <sup>2</sup>	State
<b>Plans Involved in Outreach and Education</b>	No direct marketing but can attend health fairs and mail materials to beneficiaries upon request	No direct marketing but can attend health fairs and mail materials to beneficiaries upon request	No direct marketing but can mass market and take calls from beneficiaries	No direct marketing; but HMOs can enroll during preenrollment	No direct marketing but can do mass marketing	No direct marketing but plans develop palm cards for enrollment packets	No direct marketing but can mass market, take beneficiary calls & attend health fairs	No direct marketing but can attend health fairs	No direct marketing but can mass market	No direct marketing but can mass market and take calls from beneficiaries
<b>Provider Involved in Outreach/ Education and Enrollment</b>	Enrollment forms available in providers' offices up to 90 days post-implementation	Enrollment forms available in providers' offices up to 90 days post-implementation	May help own patients with enrollment form; beneficiaries may call at providers' offices to enroll	May inform patients about MediPass; may inform patients of plan affiliations	May inform patients of plan affiliations and counsel patients about plan selection	May inform patients of plan affiliations	May inform patients of plan affiliations	May inform patients of plan affiliations	May inform patients of plan affiliations	May inform patients of plan affiliations
<b>CBO Involved in Outreach/ Education and Enrollment</b>	Yes, Broker contracts and places staff w/ CBOs	No	Yes, Broker must contract w/ CBOs	Not really, state level consumer Workgroup meets periodically	Yes, Broker must contract w/ CBOs	Yes, Broker must contract w/ CBOs	No longer	Yes, State contracts w/ CBOs for outreach to special needs populations	No	No
<b>Broker Oversight of CBO Activities</b>	Extensive	None	Moderate	Not Applicable	Moderate	Moderate	None	Moderate	None	Not Applicable

	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
<b>Provider Information Available</b>	Yes, but cumbersome directories that were difficult to use	Yes, but cumbersome directories that were difficult to use	No	No <sup>3</sup>	Yes, but directories were often inaccurate	No <sup>4</sup>	No <sup>5</sup>	Yes, but panels were incomplete and no info for Region I	No	No
<b>Method of, Outreach and Education Prior to and After Start-up</b>	Broker developed broad marketing campaign thru radio, billboard and bus signs, and posters for providers, CBOs and welfare offices; Broker and CBOs do community-based health fairs; Broker operates call line	State sponsored radio and TV interviews, legislative debates, and public forums; Advertising campaigns including billboards; broker provides community-based health fairs and operates call line	Broker's presentations are main vehicle for outreach and education	Enrollment booklets mailed to beneficiaries; No centralized outreach and education program	State sponsored public events and promoted media coverage, PSAs on radio and TV, and posters at schools, CBOs, religious and advocacy groups and county offices; Broker operates call line and provides community-based outreach	State held public forums with plans, providers and advocates; State operates helpline; Broker and CBOs provide community-based presentations; Broker is developing video	State holds quarterly meetings w/advocates, beneficiaries; state works w/ CBOs on general education and outreach via bus placards and newspaper ads	State ran PR w/ newspaper and radio ads, billboards, posters, fliers, and videos; state worked w/ local public health offices to do outreach w/mobile health vans; health fairs were primary outreach	State's initial efforts used TV, radio & newspapers State sponsored community meetings and education sessions; videos shown at county welfare offices	Individual enrollee choice counseling is main vehicle for outreach and education; State trains outstationed workers at local sites, including FQHCs, DSH hospitals, on how to choice counsel
<b>Notable Issues/ Effectiveness of Outreach and Education</b>	Delay in start-up led to improvements in outreach and education efforts, including CBO involvement & development of materials in several languages	Outreach and education efforts viewed by informants as minimal	Initial enrollment was rushed due to lack of info; Under its Medicaid expansion and CHIP program, state outreach and education efforts will increase "dramatically"	Ineffective and practically nonexistent outreach and education; HMOs primary source of information to beneficiaries	Rapid start-up left little time to prepare beneficiaries for managed care; Broker not fully prepared for rush to enroll	State did not include beneficiaries converting from PSP (PCCM) in education efforts to ease transition to full-risk managed care	Knowledge of DFS workers on enrollment process and eligibility requirements for managed care varied by county due to variable training efforts	State contracted w/ six CBOs to expand outreach efforts to special needs populations	Primary responsibility on DHS workers who could not give adequate education to enrollees;	Expansion of outstationed choice counseling underway to include all hospitals

<sup>1</sup> Because of these problems, Florida will be introducing use of broker in Summer or Fall of 1998.

<sup>2</sup> Broker's involvement was very minimal at time of site visit but more involvement is planned.

<sup>3</sup> Provider information is available from plan during pre-enrollment; provider is specified in MediPass assignment letter

<sup>4</sup> Broker maintains provider network files which are available to beneficiaries who call to enroll.

<sup>5</sup> Broker maintains provider network files which are available to beneficiaries who call to enroll.

**TABLE 6 ENROLLMENT PRACTICES 'RING IMPLEMENTATION**

	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
<b>Date Began Enrollment</b>	January 1998	February 1997	August 1995 (two counties) January 1996 (statewide)	September 1995 (full conversion)	June 1997	September 1997 (5-county area)	June 1995 (east) January 1996 (central) October 1996 (west/ northwest)	Region I: 5/97 Region II: 8/97 Region III: 1/98 Region IV: 5/98	4/96: AFDC 7/98: SMI/SED 7/99: SSI and dual eligibles	2/94: AFDC 1/95: SSI, foster kids, expanded AFDC
<b>Period for Initial Implementation and Conversion</b>	7 months	3 months	12 months (statewide)	AFDC: 3 months SSI: 10 months	5 months	7 months	Approximately 2 months in each region	6 weeks to 2 months for each phase	1 year	10 months
<b>Conversion of Eligibles</b>	County-wide divided among 7 months of implementation	Beneficiaries county-wide were required to choose a plan during the first 3 months	Voluntary for two months in two counties and then tied to eligibility redetermination	Occurred progressively by county	Divided among 5 months of implementation	Occurred first in 5 most populous counties; under in rest of counties	Occurring gradually by region in most populous areas first	Occurred in 4 phases by region - most populous areas converted first	Tied to biannual eligibility redetermination	Not applicable
<b>Length of Choice Window</b>	30 days	30 days	60 days	30 days	21 days (flexible to 28 days)	30 days	30 days	16 days	14 days	45 days
<b>Use of Broker</b>	Yes	Yes	Yes	No	Yes	Yes	Yes	No (fiscal agent)	Yes	No
<b>Voluntary Enrollment Rate</b>	60%	60%	80%	26%	±60%	50%	80%	60% (Region I)	30%	90%
<b>Plan Lock-in</b>	No	No	No	No	Yes	Yes <sup>1</sup>	No	Yes <sup>1</sup>	Yes	Yes
<b>Effort to Match Beneficiary to Prior Provider</b>	Yes	No	No	No	Yes	No	No	No	No	No
<b>Notable Enrollment Issues</b>	HCFA delayed enrollment by 6 months to allow for community involvement and improvements in enrollment materials; very complex MC structure	Implementation delayed; tension between LI and CP regarding start date; need to improve enrollment materials	Confusion during voluntary enrollment period and rush to enroll; key stakeholders were unformed	Minimal outreach and education efforts; very low voluntary enrollment rate; plans engage in direct pre-enroll contact with beneficiaries	Very rapid enrollment; and serious data problems; state extended choice window beyond 21 days due to high AE rate;	State focused on conversion process and not on efforts to inform beneficiaries about change to new managed care program	Regional implementation process allowed later regions to learn from earlier implemented regions' experiences	Provider panels not complete in Phase I; SMI had serious problems; state tried to use CBOs to improve enrollment for special needs populations	DHS workers responsible for enrollment, was not well informed or equipped to manage the process; very low voluntary enrollment rate	None reported

<sup>1</sup> Lock-in available only to federally-qualified HMOs.

**TABLE 7 ENROLLMENT BROKER CHARACTERISTICS**

	California'		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
<b>Use of Btoker</b>	Yes	Yes	Yes	No	Yes	Yes	Yes	No'	Yes	No'
<b>Current Contractor</b>	MAXIMUS	MAXIMUS	Benova	Benova <sup>1</sup>	Foundation Health (Benova <sup>5</sup> )	MAXIMUS	First Health	Consultec	Benova	Not applicable
<b>Competitive Bid Responsibilities</b>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Not applicable	Yes	Not applicable
<b>Pre-Enrollment</b>	High	Moderate	High	Proposed	Moderate	High	Moderate	Moderate	Low	Not applicable
<b>Post-Enrollment</b>	Develop educational materials; provide outreach to beneficiaries; conduct community-based presentations	Provide outreach to beneficiaries; conduct community-based presentations	Develop educational materials, Provide outreach to beneficiaries, conduct community-based presentations	Being developed	Provide outreach and education to beneficiaries	Develop educational materials; conduct community-based presentations and in-home visits	Develop education materials; provide outreach; conduct community-based presentations during phase-in of new region	Assist w/material development; responsible for provider education		
<b>Coordination with CBOs</b>	Process disenrollment forms	Process disenrollment forms	Process disenrollment forms	Being developed	Process disenrollments	Process disenrollments		Provide limited post-enrollment problem solving; process disenrollments	Provide limited post-enrollment problem solving	
	Yes	No	Yes	No data	Yes	Yes	No	No <sup>8</sup>	No	Not applicable

	California'	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon	
	Los Angeles County	Santa Clara County								
<b>Notable Features of Broker Involvement</b>	Contracted w/28 CBOs in 45 sites to provide presentations in all languages; contracted w/ 19 CBOs to provide outreach and education; arranged lease agreement w/9 CBOs to outstation broker staff on site	Expect to increase CBO involvement based on success in Los Angeles County	Subcontracted w/CBO umbrella organization to provide outreach and enrollment education	State decided to use broker b/c legislature will not permit lock-in period w/o full choice counseling program	State required broker to subcontract with community and advocacy groups to conduct outreach and education for special populations	Broker has in-house field coordinator and four regional coordinators to conduct outreach; subcontracts to 3 CBOs - 2 Arab American organizations and 1 umbrella community action agency	Broker contract formerly included community-based presentations, but funds were reduced and presentations were ceased	State expanded contract w/fiscal agent to include basic enrollment broker functions	SoonerCare helpline/ broker call center operated remotely from location in Oregon; broker only recently placed senior official on-site in Oklahoma City	State contracts prison labor to operate call center to answer basic questions and mail enrollment packets; state trains outstationed workers to provide choice counseling; informants comment that use of broker's services was beneficial for providing community presentations

<sup>1</sup> Maximus assumed responsibility for enrollment from Benova in January 1997.

<sup>2</sup> New Mexico does not use the services of an enrollment broker, but extended its fiscal agent's contract to provide some of these services.

<sup>3</sup> During implementation Oregon contracted with Benova to provide enrollment brokers services.

<sup>4</sup> Florida is currently implementing its broker contract with Benova.

<sup>5</sup> Foundation Health was the enrollment broker for Maryland until July 1998.

<sup>6</sup> We acknowledge Mary Kenesson at Health Policy Crossroads for providing the framework for this data in her work, *Programs*. Waterford, Virginia. November 1997.

<sup>7</sup> In California and Connecticut the broker also screens medical exemption requests.

<sup>8</sup> The state contracted directly w/community-based organizations (CBOs).

*Findings from the Survey of State Medicaid Managed Care*

TABLE 8 SELECTION OF PRIMARY CARE PROVIDER

	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
<b>PCP Selection at Enrollment<sup>1</sup></b>	Yes, strongly encouraged	Yes, encouraged	No, not Available	Yes, available <sup>2</sup>	Yes, strongly encouraged	Yes, encouraged	Yes, encouraged	Yes, encouraged	Yes, available	No <sup>3</sup>
<b>Broker Required to Ask<sup>4</sup></b>	Yes	Yes	No <sup>4</sup>	Not applicable	Yes	Yes <sup>4</sup>	Yes	No	No	No
<b>Availability of Provider Network Information<sup>5</sup></b>	Yes, but cumbersome directories that were difficult to use	Yes, but cumbersome directories that were difficult to use	No	No <sup>6</sup>	Yes, but directories were often inaccurate	No <sup>7</sup>	No <sup>8</sup>	Yes, but panels were incomplete and no directories for Region I	No	No
<b>Require Plan to Give Member PCP Choice<sup>9</sup></b>	No	No	Yes	No	No	No	No	Yes	No	Not applicable
<b>Time Frame for Assignment of Non-Selecting Members</b>	7 days	7 days	5 or fewer days	Before effective enrollment date(few days)	No data	10 days	15 days	30 days (period for beneficiary to choose)	14 days	30 days
<b>Match Non-Choosing Beneficiaries with Provider</b>	Yes	No	No	No	Yes	Informal effort	No	No	No	Not applicable

<sup>1</sup> All states, except Oregon, included a place on the enrollment form to indicate a PCP choice. In the case of Florida, PCP choice could be indicated on the plans' pre-enrollment forms.

<sup>2</sup> Beneficiaries can choose at time of pre-enrollment to plan (plan marketers assist beneficiaries) or with assignment to MediPass provider.

<sup>3</sup> Plans have advocated for PCP choice at time of enrollment

<sup>4</sup> Broker conducted PCP choice pilot in 1996 and will begin to solicit PCP choice at enrollment as of July 1998.

<sup>5</sup> Broker encourages focus on location of PCP in helping beneficiaries select a plan.

<sup>6</sup> Provider information is available from plan during pre-enrollment; provider is specified in MediPass assignment letter

<sup>7</sup> Broker maintains provider network files which are available to beneficiaries who call to enroll.

<sup>8</sup> Broker maintained provider network files which are available to beneficiaries who call to enroll; provider directories are included in enrollment packets as of July 1998.

<sup>9</sup> While contracts between the state and plans require plans to give non-choosing beneficiaries a chance to choose their provider, these requirements are subject to the provision "when practicable. Only two states require plans to give non-choosing beneficiaries a chance to choose their PCP notwithstanding practicalities. Also, while these contracts require and/or encourage plans to honor PCP choice, this is again subject to the plans' judgment about practicalities but does not appear to be subject to much state oversight. All plans reportedly allow beneficiaries to switch providers freely although some plans may limit the number of switches allowed per year.

TABLE 9 MANAGED CARE PLAN SWITCHING

California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
Los Angeles County	Santa Clara County								
Monthly without cause	Monthly without cause	Monthly without cause	Anytime without cause	Without cause within 30 days	Anytime without cause'	Anytime without cause	Anytime without causer	Without cause within 30 days	Switch only with cause
Request disenrollment materials by telephone or by postcard and complete disenrollment form	Request disenrollment materials by telephone or by postcard and complete disenrollment form*	Request disenrollment materials by telephone or by mail and complete disenrollment materials	Switch from MediPass to a HMO or from a HMO to MediPass by calling AHCA; switch between HMOs by calling the state or the HMO or by mail through the plan	Switch by calling broker	Switch by calling broker	Switch by contacting state	Switch by calling fiscal agent	Must contact OHCA/state to switch	Must apply to OMAP/state for good-cause switches
No	No	No	No	Yes	Yes, if federally-qualified HMO	No	Yes, if federally-qualified HMO	Yes	Yes
4-5% (disenrollment rate)	No data	21% (cumulative plan switch rate)	No data	No data	No data	2% (plan switch rate)	13% (plan switch rate)	7% (plan switch rate)	No data
Disenrollment form is same form used for enrolhments -- switching actually results in disenrollment from one plan and enrollment in another (in another offices)	Not clear whether change in availability of disenrollment forms has affected the switch rate (no longer available in providers' offices)	Advocates believe that beneficiaries switch plans instead of using grievance procedures to problem solve; state considering implementing lock-in policy	Disagreement among informants regarding how long it takes to effect a plan switch	More flexible switch policy, i.e., allowed more than one "free" switch	During open enrollment, beneficiaries are notified of their right to switch, but they are not provided w/forms to initiate switch- effort to discourage beneficiaries	State can expedite for cause (15 days) and emergency switches (3 days); standard switches can take 45 to 60 days to process	For-cause switch requests must be made in writing to the state	State applies liberal interpretation of 30-day free switch rule and AE beneficiaries frequently given 60 days to switch; loose interpretation of "good cause"	State hopes to expedite biannual re-enrollment process by sending beneficiaries copies of original eligibility application to be verified and returned

vs if federally-qualified HMO.  
available in providers' offices until 90 days post-conversion,



**TABLE 10 AUTOENROLLMENT POLICIES, ACTIVITIES AND CHARACTERISTICS**

	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
<b>Autoenrollment Rate</b>	40% initial 32% current	40% initial 29% current	20% initial 10% current	74% initial 74% current	40+% initial 40% current	50% initial 50% current	20% initial 20% current	40% initial 48% current	70% initial 60% current	10% initial 0% current'
<b>Length of Choice Window</b>	30 days	30 days	30 days	30 days	21 days	30 days	30 days	16 days	14 days	45 days
<b># of Notices or Calls Before Autoenrolled</b>	Enrollment packet and two follow-up notices	Enrollment packet and two follow-up notices	Enrollment packet, three attempts at phone contact	One mailed notice with brochure	Enrollment packet and one mailed follow up letter	Enrollment packet and one mailed reminder letter	Enrollment packet; several phone calls; reminder card	One mailed enrollment packet*	One mailed notice	Mostly outstationed enrollment so no notices
<b>Calculation of Autoenrollment Rate – Who is Counted?</b>	Family as unit, Re-enrollees count as AE if > 60 days	Family as unit, Re-enrollees count as AE if > 60 days	Family as individuals; re-enrollees count as AE if >60 days	Family as individuals; re-enrollees count if >90 days	Newborns, family as individuals Re-enrollees count as AE if > 90	Family as individuals	Family as unit, re-enrollees count as AE if >90 days	Newborns, family as individuals; re-enrollees count if >1 80 days	Family as individuals; re-enrollees count if >90 days	Not applicable
<b>Who Identifies and Distributes AE Lives</b>	State	State	State	State	State	Broker and State'	State	Fiscal Agent	State	Not applicable
<b>Preferred AE Distribution</b>	Yes	Yes	No <sup>4</sup>	Yes (HMO vs. PCCM)	No	Yes	Yes	Yes	Yes	Not applicable
<b>Method for Distributing AE Lives</b>	All lives to local initiative plan	All lives to local initiative plan	Random	% to PCCM and % to HMOs <sup>5</sup>	Random	Plans ranked by competitive bid score <sup>7</sup>	Plans ranked by competitive bid score	Plans ranked by competitive bid score	Plans ranked by competitive bid score <sup>6</sup>	Not applicable
<b>Match AE with Prior Provider</b>	Yes	No	No	No	Yes	No	No	No	No	Not applicable
<b>Plan Switch Policy</b>	Monthly without cause	Monthly without cause	Monthly without cause	Anytime without cause	Within initial 30 days without cause	Anytime without cause <sup>8</sup>	Anytime without cause	Anytime without cause <sup>8</sup>	Within initial 30 days without cause	Switch only with cause
<b>Notable AE Features or Issues</b>	Two-plan model -state decision to support public plan	Two-plan model • state decision to support public plan	Initial policy favored two plans w/high scores to have good outreach, now all plans get AE lives	AE lives reassigned to PCCM if no plan contact or service utilization within 4 mos	Effort to match AE lives with emphasis on previous provider relationship	Plans' performance could result in reallocation of AE lives	AE policies and lives appeared to be an unimportant factor	State developed AE policy to encourage plan participation and support SALUD!	Support for public plan; AE lives reassigned to FQHCs if no plan contact w/in 90 days	Not applicable

<sup>1</sup> Incomplete enrollment forms (i.e., missing plan choice) will be returned to applicant (no autoenrollment occurs).

<sup>2</sup> Reminder cards were also sent during implementation of a region 2 to 3 weeks before the close of enrollment.

<sup>3</sup> The broker autoenrolls beneficiaries who do not make a choice and the state autoenrolls newborns and re-enrollees.

<sup>4</sup> Until recently the state split autoenrolled lives between East and West.

<sup>5</sup> In early 1998, legislation proposed to assign all autoenrolled lives to HMOs until parity with PCCM program was reached, and then autoenrolled lives would be awarded to preserve the 50/50 parity in overall enrollment. Whether this approach went into effect was dependent upon Florida gaining approval for its waiver, which was not known at the time of this report. The practice had been to award autoenrolled lives based on the relative percentage of overall HMO and PCCM voluntary enrollment, which percentage could change if PCCM or HMOs were successful in gaining more voluntarily enrolled lives.

<sup>6</sup> Top five ranked plans.

<sup>7</sup> Preference was given to university-sponsored plan.

<sup>8</sup> Without cause within 30 days if federally-qualified HMO

TABLE 11 PLAN PARTICIPATION IN MAND. ORY MEDICAID MANAGED CARE

	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
<b># of Plans</b>	2	2	7	15 <sup>1</sup>	9	18	12	3	5	15
<b>Type of Plans</b>	Commercial; Local Initiative <sup>2</sup>	Commercial; Local Initiative	2 FQHC-owned	2 publicly-sponsored	2 FQHC-owned	1 FQHC-owned	2 FQHC-owned 1 publicly-sponsored	All commercial	2 publicly-sponsored	1 FQHC-owned
<b>Plan Selection</b>	Competitive bid for CP	Competitive bid for CP	State certification	State certification	Competitive Bid	State certification	Competitive Bid	Competitive Bid	Competitive Bid	State certification
<b>Basis for Selecting Plans</b>	Price/ Technical Capacity (CP)	Price/ Technical Capacity (CP)	Price/ Technical Capacity	Technical Capacity	Technical Capacity	Technical Capacity	Price/ Technical Capacity	Price/ Technical Capacity	Price/ Technical Capacity	Technical Capacity
<b>Plan Incentives</b>										
1) AE Awarded Based on Score	Yes	Yes	No <sup>3</sup>	Yes <sup>5</sup>	No	Yes	Yes	Yes	Yes	Not applicable
2) Lock-in Policy	No	No	No	No	Yes	Yes <sup>7</sup>	No	Yes <sup>7</sup>	Yes	Yes
3) Guaranteed Eligibility	No	No	Yes <sup>4</sup> 6 mos.	Yes <sup>6</sup> 12 mos.	Yes 6 mos.	No	No	No	Yes 6 mos.	Yes <sup>8</sup> 6 mos.
4) Retroactive Re-enrollment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No
<b>How Capitation Rates are Set</b>	Negotiate	Negotiate	Rate setting	Rate setting	Rate setting	Rate setting	Negotiate	Competitive Bid	Competitive Bid	Rate setting
<b>Notable-Features of Plan Participation</b>	Tensions between LI and CP (CP receives fewer lives) in light of falling Medicaid rolls	Tensions between LI and CP (CP receives fewer lives) in light of falling Medicaid rolls	Potential for more plans dropping out after loss of two large commercial plans	Plans permitted to enroll in "pre-enrollment" process; Plans slated to receive all AE lives until parity is reached w/MediPass	Plans not happy about instability of plan membership and state allowances for free switches	Diversity of plans: clinic plans, federally-qualified HMOs and non-federally-qualified HMOs	Plans concerned about neutral development of MC+ broker role encouraged participation	Potential envelopment of tribal health plan as competitor to 3 participating plans	Plans all losing money; concerns about future participation in SoonerCare	Difficulty recruiting plans for rural areas

<sup>1</sup> At the time of our site visit in Spring 1998, an FQHC-owned plan was close to being operational.

<sup>2</sup> Important to note, however, that the commercial plan has two plan partners and the local initiative plan has seven plan partners for a total of eleven participating plans.

<sup>3</sup> Until early spring 1998, the state awarded autoenrolled lives by dividing the state into east and west sections and awarding lives to one plan operating in each region

<sup>4</sup> Guaranteed eligibility for six months was instituted in July, 1998.

<sup>5</sup> Certain percent is awarded to HMOs and a certain percent is awarded to MediPass/PCCM providers.

<sup>6</sup> Guaranteed eligibility for children was instituted July 1998.

<sup>7</sup> Lock-in available only for federally-qualified HMOs.

<sup>8</sup> Six months of guaranteed eligibility is available only for noncash-assistance eligible beneficiaries.

TABLE 12 PROFILE OF FQHCs

Characteristic	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
# of FQHCs	15	2	11	32	12	31	14	16	4	12
# of Urban FQHCs <sup>1</sup>	30		5	13	6	12	7	3	2	3
# of Rural FQHCs <sup>1</sup>	15		0	15	4	14	6	7	1	9
Total Revenues 1996	\$338,760,515		\$22,263,375	\$122,982,643	\$86,410,843	\$71,120,294	\$53,433,389	\$56,733,928	\$5,358,983	\$57,724,213
# of FQHC-Sponsored Plans	0	0	2	1 <sup>2</sup>	2	1	2	0	0	1
# of ISNs	1	0	1	3	2	1	3	1	1	1
Total FQHC-Users										
1995	837,108		15,050	490,846	15,559	194,041	159,677	142,875	3,1062	106,608
1996	941,860		87,024	442,055	16,863	208,182	161,651	145,766	18,839	121,583
% Change	12.5%		-24.3%	-9.9%	1.1%	7.3%	1.2%	2%	-39.3%	14%
Medicaid Users										
1995	317,850 (38%)		61,711 (53.6%)	149,523 (30.5%)	47,263 (40.9%)	80,171 (41.3%)	63,339 (39.7%)	35,766 (25%)	7,895 (25.4%)	36,846 (34.6%)
1996	373,702 (39.7%)		40,633 (46.7%)	116,330 (26.3%)	47,053 (40.3%)	71,622 (34.4%)	56,499 (45.3%)	40,730 (46.9%)	3,236 (72%)	41,418 (50.4%)
% Change	17.6%		-34.2%	-22.2%	-0.4%	-10.7%	-10.8%	13.9%	-59%	12.4%
Uninsured Users										
1995	258,105 (30.8%)		25,544 (22.2%)	259,331 (52.8%)	35,223 (30.5%)	54,911 (28.3%)	59,915 (37.5%)	60,448 (42.3%)	18,631 (60%)	56,677 (53.2%)
1996	340,724 (36.2%)		17,990 (20.7%)	232,331 <sup>1</sup> (52.6%)	29,509 (25.3%)	71,646 (34.4%)	73,272 (45.3%)	68,433 (46.9%)	13,571 (72%)	61,282 (50.4%)
% Change	32%		-29.6%	-10.4%	-16.2%	30.5%	22.3%	13.2%	-27.2%	8.1%

<sup>1</sup> Data from 1996 UDS.

<sup>2</sup> A FQHC-sponsored plan has been established but was not yet operational at the time of our case study.

TABLE 13 EXPERIENCES OF FQHCs

	California	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon	
	Los Angeles County	Santa Clara county								
<b>Autoenrollment Rate</b>	40% initial 32% current	40% initial 29% current	20% initial 10% current	74% initial 74% current	40+% initial 40% current	50% initial 50% current	20% initial 20% current	40% initial 48% current	70% initial 60% current	10% initial 0% current
<b>Reimbursement</b>										
<b>Cost-Based Reimbursement</b>	Yes	Yes	Yes	Yes	Waived/1   15	Yes	Yes	Yes	Waived/1   15	Waived/1   15
<b>Frequency of Reconciliation</b>	Quarterly for LI FQHCs Annually for CI' FQHCs'	Quarterly for LI FQHCs Annually for CI' FQHCs'	Quarterly	Quarterly <sup>2</sup>	NA	Quarterly	Monthly	Initially quarterly, now monthly	NA	NA
<b>Cost-Based Reimbursement Issues/Problems</b>	FQHCs want state to pay CBR directly & not thru CP and LI; want real-time CBR reconciliation	FQHCs want state to pay CBR directly & not thru CP and LI; want real-time CBR reconciliation	Reinstated CBR 10/1/97; FQHCs worked to get CBR back under 19 15(b) after state "waived" it	FQHCs get CBR from plans & claim payments are inadequate want CBR from state	No transition payments	Initially plans responsible for CBR payments to FQHCs; now state pays directly to FQHCs	FQHCs have good working relationship with state, monthly CBR an important result	FQHCs worked to ensure adequate calculation of CBR; state auditing prior cost allowances	Minimal transition payments	No transition payments
<b>Medicaid: # of Patients</b>	Unclear "disruptions in patient access" noted	Some losses	Varied from substantial increases to moderate losses	Varied from substantial increases to moderate losses	Substantial losses	Varied from some to substantial losses	Varied from some to moderate losses	Moderate losses	Varied from moderate to substantial losses	Varied from no change to substantial losses
<b>Changes Attributed to</b>	Reduced Medicaid rolls	Reduced Medicaid rolls	Unclear	Aggressive plan enrollments, increased competition	Failure of historic provider protection	Too early to tell	Unclear	Unclear among several factors	Errors in enrollment, reduced Medicaid rolls	Unclear
<b>Revenue Change</b>	Some losses	Some losses	Moderate to substantial losses initially	Substantial losses	Substantial losses	Some losses	Some losses	Moderate losses	Substantial losses	Substantial losses
<b>Changes Attributed to</b>	Too early to tell	Too early to tell	No CBR until 10/1/97	Inadequate CBR payments	No CBR, no transition, low cap rates	Too early to tell	Offset by increased number of encounters	CBR dispute, high MC costs	No CBR, minimal transition payments	No CBR, no transition
<b>Adequacy of FQHC MIS to Monitor Changes</b>	Few able to document changes	Unclear	Needs to improve	Better able to track patients and revenues but new system	Inadequate	Inadequate	Varied; considerable cost to update MIS	Inadequate	Inadequate	Inadequate, considerable cost to update

	California	Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon	
	Los Angeles County	Santa Clara County								
<b>Ability of FQHCs to Participate in Medicaid Managed Care Program</b>	Complexity dealing with multiple plan partners; increased MC administrative burdens; difficulties obtaining contracts b/c of delays in 2-plan start-up and payment rate negotiations	More favorable relationships and reimbursement from LI than with CP	Plan credentialing process lengthy but not uniquely difficult for FQHCs; increased MC administrative burdens	FQHCs reluctant at first to participate and had PCCM "out" with MediPass	No difficulties but FQHCs struggled with figuring out exclusivity agreements with plans	No serious difficulties	Varied; some difficulty in obtaining favorable contracts; credentialing process lengthy but not uniquely difficult; increased MC administrative burdens	Plan credentialing difficult; increased MC administrative burdens; difficulty obtaining plan contracts to cover unique and/pr innovative FQHC services	Difficult to negotiate an acceptable or adequate capitation rate; plan credentialing difficult for one FQHC	Difficult to negotiating acceptable cap rate; higher MC administrative burdens; difficulties in obtaining favorable contracts; plan credentialing difficult
<b>State Policies Designed to Support FQHCs</b>	2-plan model; LI required to offer contracts to all FQHCs; AE lives assigned to LI plan until enrollment reaches financial viability means more lives for SNPs	2-plan model; LI required to offer contracts to all FQHCs; AE lives assigned to LI plan until enrollment reaches financial viability means more lives for SNPs	FQHC-sponsored plans can meet more lenient licensure rules	Multi-million dollar appropriation for special FQHC projects (one time only)	Historic provider protection requires networks to include all historic providers	Plans that included FQHCs in network during competitive bid process received extra points	CBR monthly payments helped with cash flow during transition	State legislature willing to approve additional funds for FQHC during transition but governor vetoed	State assigns beneficiaries to FQHC provider if plan cannot contact member within 90 days	State pays FFS to providers for pre-MC services; state allocated \$3.2 million from tobacco taxes to SNPs in FY98 (one time only)
<b>FQHC Strategies to Respond to MMMC</b>	Interest in contracting for full risk; need to develop MIS; focus on patient retention and market share	Maximize Medicaid eligibility; focus on patient retention; interest in contracting for full risk	Establish FQHC-owned plans	Establish FQHC-owned plan; FQHC network; limit services; pursue bill collection and maximize eligibility determination	Establish FQHC-owned plan; reduce staff and services	Establish FQHC-owned plan; rely on public and private sources of funding (e.g., grants)	Establish FQHC-owned plans	support development of PHO and ISN and joint MIS	Reduce staff and services	Establish FQHC-owned plan; seek reinstatement of CBR; close 2 FQHCs

<sup>1</sup> Effective October 1, 1998, commercial plans (CP) are required to provide quarterly CBR payments to FQHCs as local initiative plans (LI) are required.

<sup>2</sup> HMOs are required to report rates paid to FQHCs and certify that rates are comparable to other providers. State will determine if wrap-around payments are needed through CBR reconciliation.

**TABLE 14 EXPERIENCES OF BENEFICIARIES**

	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
<b>Enrollment Procedures and Materials</b>	Many reported difficulties and lack of understanding, high among Asian Americans who relied on providers to enroll them	Better-educated beneficiaries more equipped to understand process. Otherwise confusing and overwhelming	Most received & understood enrollment materials; Most did not understand they would be autoassigned for failing to select a plan	Inadequate information to understand MC options; Some were AE even though chose plans; Adequate Spanish translation	Mixed reports of ease and difficulties; HIV-infected beneficiaries report problems w/ provider link	Most confused or unaware of enrollment process	HIV-infected beneficiaries reported no difficulties for the most part	Sufficient time to choose but inadequate information to choose a plan; Language issues w/ Native Americans	Mixed reports of ease and difficulties	Adequate information to make a choice for HIV-infected beneficiaries
<b>Informant Comments</b>	Enrollment materials were challenging to understand			Misinformation from plans	Major data problems block provider link			So little information about plans and providers		Information available for HIV-infected.
<b>Education and Outreach Adequacy of Information</b>	Asian American beneficiaries not aware of broker hotline. Lack of clear information about Plan Partners	Little or no information	Presentations reached few beneficiaries and materials were confusing	Hispanic beneficiaries received little information; Most materials available only in English	Aware of media coverage; No comparative information on plans so sought guidance from providers	Complaints about hotline. Little or no information	HIV-infected beneficiaries received info from special care center	Provider lists not available or incomplete. Materials confusing. Educational fairs unhelpful. Materials available in Spanish.	Most had little knowledge of <b>SoonerCare</b> and received minimal info from caseworkers	<b>HIV-infected</b> beneficiaries were well informed - special case management services
<b>Informant Comments</b>	Beneficiaries overwhelmed by information and process		Beneficiaries not understand MC after enrollment	No information given about meaning of being in MC	Not enough time to educate beneficiaries about MC		Case management services very helpful	Health fairs did not meet beneficiaries' needs	Very poor efforts to inform	
<b>Choosing Plans and Choosing Providers</b>	Asian American wanted physicians to help	Previous provider important to choice	Previous provider important to choice	Aggressive marketing affected choice; More freedom & information under PCCM to choose	Prior provider and location important to choice	Did not understand difference between choosing a plan or a provider	Prior provider somewhat important to choice	Providers informed beneficiaries about plan affiliations		Prior provider some problems with random assignment
<b>Switching Providers &amp; Plans</b>	Most aware, except Asian Americans	Aware but few did switch	Most unaware	Difficult			Able to switch	Aware but few did despite dissatisfaction	Most believed provider switch limited to twice	No problems

	California		Connecticut	Florida	Maryland	Michigan	Missouri	New Mexico	Oklahoma	Oregon
	Los Angeles County	Santa Clara County								
<b>Informants Comments</b>			No provider information available for switching	Hard for beneficiaries to disenroll	Beneficiaries did n't know how to switch					
<b>Ability to Navigate Managed Care System</b>	Reluctance to use grievance	Better-educated beneficiaries more equipped to navigate Reluctance to use grievance	Most understood how to access primary care but uncertain about how to access specialty care	Complaints about obtaining referrals and authorization for services		Unaware of grievance; complaints re obtaining referrals and authorization; Newly-eligible had most difficulty	Complaints re obtaining referrals and authorization; Beneficiaries assisted by providers	Complaints about obtaining referrals and authorization for services		No confusion about plan rules among HIV-infected beneficiaries Complaints re authorizing emergency care
<b>Informant Comments</b>	No info on MC so beneficiaries not able to use		Too easy to switch providers to solve problems	Hard to navigate for special needs	Beneficiaries not know how to deal with MC			Lack of MC info very difficult for special needs	Special needs have problems	Case management very important
<b>Access to Care Notable Issues</b>	Problems with mental health services, specialty and emergency care; language and transportation barriers for Asian Americans	Autoenrolled beneficiaries experienced difficulties when obtaining care from non network providers	Most understood how to access primary care, Specialty care presented some difficulties	Long waiting times, and inconvenient locations;	Increased access to services (e.g., dental, vision)	Long waits for care; perceived discrimination based on Medicaid status; High level of satisfaction for beneficiaries enrolled in HMOs for several years	Successful access by HIV-infected beneficiaries due to case management services	Specialists, prescriptions, perceived discrimination based on Medicaid status; believed providers limit or withhold treatment to save money Poor work with Native Americans	Increased access to services (e.g., dental, prescriptions)	Long waiting times, emergency care; improved access for HIV-infected beneficiaries, except rural beneficiaries
<b>Informant Comments</b>	Access will be affected unless MC info is improved				Some delays due to initial enrollment chaos					Case management stand-out service

**APPENDIX A**  
**Research Methods**

## Research Methods

This multi-phase study of managed care enrollment practices in states using mandatory Medicaid managed care arrangements is funded by the Center for Health Care Strategies, a Robert Wood Johnson Foundation-funded project, The David and Lucile Packard Foundation, the Kaiser Family Foundation, and the Health Resources and Services Administration Bureau of Primary Health Care (HRSA/BPHC).

Enrollment policies and practices provide the broad context for understanding how autoenrollment policies and practices as well as other important elements of the enrollment process, such as education and outreach for Medicaid beneficiaries, influence the implementation of mandatory Medicaid managed care, affect the willingness of managed care plans to participate, shape the experiences of Medicaid beneficiaries as they leave a fee-for-service healthcare system, and determine their ability to operate in a managed healthcare system. Of special interest for this study is the effect of state enrollment policies and practices on federally qualified health centers (FQHCs) and their ability to participate successfully in mandatory Medicaid managed care.

The first phase of this study examined the role of autoenrollment in mandatory Medicaid managed care (MMMC). We assessed the existing knowledge about autoenrollment in managed care and the potential effects of autoenrollment on beneficiaries, and we reviewed autoenrollment policies and practices in approximately 34 states with mandatory Medicaid managed care. We found that the available knowledge about autoenrollment and autoenrollees is very limited and that states' autoenrollment policies and practices are highly variable. We concluded that **autoenrollment** would probably continue to play a role in the development of Medicaid managed care markets, and that autoenrollment had the potential to affect disproportionately Medicaid beneficiaries and the providers that traditionally serve them.

The second phase of the study involved a more detailed examination of the states' enrollment policies and practices under mandatory Medicaid managed care by conducting a series of case studies using nine states. The case study approach involved the use of focus groups to produce an in-depth assessment of the experiences of Medicaid beneficiaries enrolling in managed care. This research also carefully examined the

experiences of providers that traditionally serve these beneficiaries, with a particular emphasis on federally qualified health centers (FQHCs) in order to assess the effects of the dynamics of mandatory Medicaid managed care on these providers and their ability to survive in a changing healthcare system.

The goals of the study were 1) the development of a better understanding of the various states' managed care enrollment policies and practices, 2) the examination of the experiences of Medicaid beneficiaries enrolling in health plans and choosing primary care providers, and 3) the examination of the experiences of traditional providers of community health services as Medicaid beneficiaries enroll in these new managed care arrangements. A particular focus of this enrollment study concerns autoenrollment -- the process whereby Medicaid beneficiaries are assigned to health plans when they do not voluntarily enroll, that is, choose, a health plan

Thus, our research questions were:

1. How are state enrollment policies and practices developing and evolving as mandatory Medicaid managed care programs are developing and evolving, particularly with respect to the use of enrollment brokers?
2. What are the specific state autoenrollment policies and practices under mandatory Medicaid managed care programs ? What role is played by these policies and practices within the context of the state's overall enrollment policies?
3. What factors related to the enrollment process affect the decisions and/or willingness of plans, either commercial or provider-sponsored, to participate in mandatory Medicaid managed care programs? Are states tailoring/developing **enrollment/autoenrollment** policies to solicit the participation of plans in their mandatory Medicaid managed care programs?
4. How are Medicaid beneficiaries affected by state **enrollment/autoenrollment** policies and practices, especially as these policies and practices affect their ability to choose providers as well 'as health plans? What are these beneficiaries' particular experiences with the process of enrollment under mandatory Medicaid managed care?
5. How are the traditional safety-net providers, especially federally qualified health centers (FQHCs), affected by state **enrollment/autoenrollment** policies and practices? Have the FQHCs experienced a loss of Medicaid patients and/or revenues due to particular enrollment/autoenrollment policies and practices?

These study questions were structured to address the important dimensions of the study objectives and to identify the major areas of inquiry for the research. As such, these study questions provided the structure for the **final** report.

Within each of these major areas of inquiry, numerous subquestions guided the data collection and data analysis. For example, subquestions under the first study question included: 1) how exactly are education and enrollment conducted, 2) what is the role of the enrollment broker, 3) what other entities, e.g., FQHCs or community-based organizations, can participate in education and enrollment activities, and 4) how are beneficiaries making their choices and what is the voluntary enrollment rate. Subquestions under the second study questions included: 1) how are autoenrollment rates measured and calculated, 2) how are beneficiaries matched with providers and plans, 3) how are autoenrolled lives distributed, and 4) are autoenrolled lives used as incentive or sanction during the enrollment process.

The third study question included these subquestions: 1) have autoenrolled lives been competitively bid or distributed with a deliberate bias toward certain plans, 2) have autoenrolled lives been viewed as a mechanism to capitalize plans, and 3) have other enrollment-related policies, such as guaranteed eligibility or lock-in periods, been used to attract the participation of plans. Subquestions under the fourth study question included: 1) how do beneficiaries understand their role, choices, and responsibilities under managed care, 2) what kinds of outreach and enrollment activities are most effective with beneficiaries, and 3) when beneficiaries don't choose a plan or provider, what is the reason for this. Finally, the fifth study question included these subquestions: 1) how easily have FQHCs been able to participate in mandatory Medicaid managed care, i.e., gain contracts with managed care health plans, 2) what approaches have FQHCs used to retain patients and gain new patients, 3) are FQHCs able to account for their losses by tracking patients and revenues and by collecting data.

The selection of case study states involved the careful analysis of numerous descriptive variables (e.g., autoenrollment rates, choice window, use of enrollment broker, how long MMMC implemented, PCCM or risk-based coverage, covered populations, FQHC experience with changes in patient volume and revenue) in the **thirty-four** states with significant mandatory Medicaid managed care activity. Based on this

analysis, we initially proposed eighteen potential sites to our

discussion, we decided on the following nine sites: California,

Maryland, Michigan, Missouri, New Mexico, Oklahoma, and O

**As** part of our preparation for the

materials including newspaper and research journal articles, rel

a copy of the enrollment packet sent out to all Medicaid benefi

emphasis on the experiences of providers that traditionally serv

we asked representatives from the National Association of Cor

**(NACHC)** and the Bureau of Primary Health

beneficiaries were conducted. The protocols for the focus groups were also designed to collect systematically data relevant to the study questions.

It is important to note that focus group results cannot be considered (nor were they intended to be) representative of all beneficiaries' experiences under these states' Medicaid managed care programs although these results do provide a rich and detailed picture of these beneficiaries' experiences within context of detailed examination of their states' programs.

The data collected from all of these various sources were analyzed and synthesized across the sites and within the analytic framework provided by the study questions to produce this report.

The following interviews comprised the Santa Clara County, California site visit:

- Interviews with representatives from two FQHCs;
- Interviews with representatives from the two health plans, the local initiative, and the commercial plan, operating under the two-plan model;
- Interviews with five community advocates;
- Interviews with state officials; and
- An **interview** with the enrollment agent representative.

Two focus groups of beneficiaries enrolled in the two-plan model were held in Santa Clara County. Sixteen women representing a diversity of racial and ethnic backgrounds (i.e., White, Hispanic, African American, Asian, and American Indian) participated in the groups.

The following interviews comprised the Los Angeles County site visit in April of 1998:

- Interviews with representatives from four urban FQHCs (two small, one mid-size and one large) and the community clinic association for LA County;
- Interviews with representatives from three health plans (the commercial plan, the local initiative plan and the county plan);
- Interviews with two community advocates;
- Interviews with state officials; and
- **An** interview with the enrollment agent representative.

Four focus groups of beneficiaries were held in Los Angeles. The objective of holding four focus groups was to conduct two focus groups composed of non-Asian American

beneficiaries (white, African-American, and Hispanic) and two focus groups composed of only Asian-American (Chinese, Japanese, Korean and Vietnamese) beneficiaries.

The following interviews comprised the Connecticut site visit in May of 1998:

- Interviews with representatives from three FQHCs (two urban and one rural);
- Interviews with representatives from three health plans (one commercial plan and two FQHC-owned plans);
- Interviews with community advocates and child health policy group
- Interviews with state officials; and
- An interview with the enrollment broker.

As described above, our case studies were especially designed to include beneficiary focus groups. However, in the case of Connecticut, as a result of unanticipated funding constraints, no beneficiary focus groups were conducted.

The following interviews comprised the Florida “site visit” in May of 1998: <sup>1</sup>

- Interviews with representatives from two FQHCs in central Florida and a FQHC network representing five FQHCs in southern Florida;
- Interviews with representatives from three health plans;
- Interviews with two community advocates; and
- Interviews with state officials.

Four focus groups of beneficiaries were held in Miami. The objective of holding four focus groups, as was the case for our New Mexico case study, was to conduct two focus groups composed of non-Hispanic beneficiaries and two focus groups composed of only Hispanic beneficiaries.

The Maryland site visit was conducted in January 1998 and involved the following interviews:

- Interviews with representatives from four FQHCs (two urban centers, one large and one mid-sized, one suburban health center, and one rural center);
- Interviews with representatives from three health plans (one provider-

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<sup>1</sup> The informant interviews for this case study were all conducted by telephone because of logistical challenges in scheduling interviews with some geographic proximity. Otherwise, the research methods used were the same as for the “on-site” case studies in terms of preparation, interview protocols, data collection and analysis.

- sponsored health plan and two commercial plans)<sup>2</sup>;
- An interview with a community advocate representing special populations;
- Interviews with state officials;
- An interview with enrollment broker representatives; and
- Interviews with Medicaid beneficiaries at clinic sites.

Two focus groups were conducted with one focus group deliberately composed of HIV-infected beneficiaries.

The following interviews comprised the Detroit and Lansing, Michigan site visit in April of 1998:

- Interviews with representatives from two urban FQHCs;
- Interviews with representatives from three health plans (a federally-qualified HMO, a FQHC plan, and a clinic plan);
- Interviews with two community advocates;
- Interviews with state officials; and
- An interview with the enrollment agent representative.

Four focus groups of beneficiaries were held in Detroit. The original objective was to conduct two focus groups to be composed of only white beneficiaries and two focus groups to be composed of only African American beneficiaries. However, all the focus groups were predominantly African American with only three white beneficiaries among a total of 32 beneficiaries in all four groups.

The following interviews comprised the Missouri site visit in June of 1998:

- Interviews with representatives from four FQHCs (three urban and one rural);
- Interviews with representatives from two health plans (one commercial plan, one hospital-sponsored plan);
- Interviews with two community advocates;
- Interview with state officials; and
- An interview with enrollment broker representatives.

We conducted a focus group composed of HIV-infected beneficiaries.

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<sup>2</sup> We were unsuccessful in interviewing a second provider-sponsored plan because of cancellations of two scheduled interviews by plan representatives.

The following interviews comprised the Albuquerque and Santa Fe, New Mexico site visit during the third week in March, 1998:

- Interviews with representatives **from** three FQHCs (two urban and one rural) and the state primary care association;
- Interviews with representatives from two health plans (the largest health plan and the health plan with an exclusive relationship with the University of New Mexico, a safety-net provider);
- Interviews with four community advocates;
- An interview with state officials; and
- An interview with the enrollment agent representative.

Four focus groups -- two focus groups composed of only white beneficiaries and two focus groups composed of only Hispanic beneficiaries -- were held in Albuquerque.

The following interviews comprised the Oklahoma City, Oklahoma site visit during the first week in March, 1998

- Interviews with representatives from three urban FQHCs and the state primary care association;
- Interviews with representatives from two health plans (one health plan contracts only with traditional providers);
- An interview with two community advocates;
- **An** interview with state officials;
- An interview with the enrollment agent representative; and
- Interview with one Medicaid beneficiary conducted on-site at a **FQHC**.

Two focus groups were held in Oklahoma City.

The following interviews composed the Oregon “site visit” in May of 1998<sup>3</sup>:

- Interviews with representatives from three FQHCs (one urban and two rural);
- Interviews with representatives from two health plans (one commercial plan and one FQHC-owned **plan**)<sup>4</sup>;
- Interviews with two community advocate organizations; and
- Interviews with state officials.

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<sup>3</sup> The informant interviews for this case study were all conducted by telephone because of logistical challenges in scheduling interviews with some geographic proximity. Otherwise, the research methods used were the same as for the “on-site” case studies in terms of preparation, interview protocols, data collection and analysis.

<sup>4</sup> We also received a written response to our question protocol from a second commercial **plan**.

We conducted a focus group composed of HIV-infected beneficiaries.

### **Selected Resources for Site Visits**

#### **GENERAL**

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3. [http://www.kff.org/state\\_health/](http://www.kff.org/state_health/) - State Medicaid statistics
4. *Health Systems Review*, California, November/December 1997.
5. Kenesson, Mary S., "Medicaid Managed Care Outreach and Enrollment for Special Populations," for the Center for Health Care Strategies, Inc., Princeton, NJ, December 1997.
6. Legislative Updates, Health Line, January 9, 1997.
7. "Major Health Care Policies: Fifty State Profiles" Health Policy Tracking Service, 1997.
8. "Medicaid and Managed Care: Focus Group Studies of Low-Income Medicaid Beneficiaries in Five States," Frederick Schneiders Research, Washington, D.C., May 1996.
9. Schwalberg, R., "The Development of Capitation Rates under Medicaid Managed Care Programs: A Pilot Study," Health Systems Research, Inc., Washington, D.C., December 1997.

#### **CALIFORNIA**

##### **General**

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